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ABSTRACT

Designed to be presented in a workshop format, by trainers, to an audience of caregivers of young children, these materials provide two modules for workshop presentations in the areas of first aid and common childhood illnesses as well as an example of a model health policy. The materials for the workshop on common childhood illness discusses in two sessions common childhood diseases, respiratory diseases, and common health problems. The materials on first aid consist of an overview of the subject plus guides for treating specific major and minor injuries. The prevention-oriented model health policy covers immunization schedules, record keeping, illness policy, emergency management, medication administration policy, discipline policy, nutrition policy, meal preparation and serving policy, outside play policy, dental health policy and provides similar information in several other areas of concern. Appendices A through L provide model health forms for child care centers. These instructional materials are thought to be appropriate for self-instruction, child development associate training, or courses at the high school, junior college or university level. (Author/RH)

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Teacher, I Don't Feel Well

Meeting Children's Health Needs

Edited by

Lynn Collins Clarke

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A Model Health Policy
and
Modules for Training Caregivers of Young Children

City/University EPSDT Day Care Project

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This book is one in a series of three:

"Teacher, I Don't Feel Well": Meeting Children's Health Needs

"Feeling Good": Helping Children Grow Emotionally and Socially

"What Do We Do Today?": Planning a Developmental Curriculum

The Project also produced a Final Report, an Executive Summary, and a parent activity booklet: "Big Hands, Little Hands Together: A Collection of Activities for Parents with Preschoolers."

All materials are available through the University of Michigan, School of Education.

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PREFACE

The City/University EPSDT-Day Care Project was a three-year research and demonstration project funded by HEW to the Michigan Department of Social Services and carried out by the joint collaboration of the University of Michigan, School of Education, and the City of Ann Arbor.

The Project served a population of approximately 750 preschool children and their families through day care centers and family day care homes in Washtenaw County. It developed a comprehensive and interdisciplinary approach to early health assessment of the children, follow-through, and training and consultation for day care staffs on behalf of the children and their families.

The Project's innovative-approach used the Early and Periodic Screening, Diagnosis and Treatment model plus making available a separate developmental assessment on-site for each child in the day care setting. In addition, teams of a nurse, social worker, and educational consultants provided systematic consultation and training to the caregivers, based on mutually set goals with day care staffs.

The services provided by the Project resulted in the development of two different workshop presentations in the areas of First Aid and Common Childhood Illnesses as well as producing a Model Health Policy. This book is published to share the content of these health education workshops and to suggest methods for presenting them.

These materials are designed to be presented in a workshop format, by trainers, to an audience of caregivers of young children. These materials are also appropriate for self-instruction, Child Development Associate Training, or courses at the high school, junior college or university level.

Each workshop includes everything a trainer needs to present the program: training objectives, factual material, suggestions for presenting the material, resource articles, follow-up ideas and handouts which may be reproduced for participants. Pages designed for and used by the Project as handouts are marked with the Project title.

The Project hopes you will find these workshops useful in enriching your day care program.

ACKNOWLEDGEMENTS

We would like to thank Abbot Laboratories, the American Red Cross, the Pediatric Nursing Journal, Ross Laboratories, Reed and Carnich, and Wyeth Laboratories for printed and pictorial materials they provided for workshops and for this module. We gratefully acknowledge the help of Susan Aronson, M.D., of the Health Advocacy Program, Philadelphia, Pennsylvania, for materials used to compile the safety check list, and Virginia Nelson, M.D., who served as medical consultant to the City/University EPSDT-Day Care Project. We would also like to thank those who contributed to the production of this book: Virginia duRivage for illustrations and layout, Karen Lind for editorial assistance, and Nancy Lux for typing.

Special thanks go the staffs of the participating day care centers. Their ideas, encouragement and forbearance contributed much to the development of these modules.

We acknowledge the entire staff of the City/University EPSDT-Day Care Project for giving so freely of their talents and energies.

Common Childhood Illnesses

Lynn Collins Clarke

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PREPARING THE WORKSHOP

Workshop Objectives

1. To provide caregivers with information about common preschool illnesses, including symptoms, treatment, and environmental control.
2. To provide caregivers with health resources information so that they can assist parents in obtaining appropriate health care.
3. To provide caregivers with appropriate methods for reporting communicable diseases to parents and to the local health department.
4. To provide ideas for caregivers to use in devising or maintaining some written communication system in relation to managing health care problems.
5. To provide ideas for caregivers to incorporate into health policies that may help them prevent illness and/or provide proper care.

Method of Delivery

Although written to be used as inservice education, this workshop generates many technical questions, and is best presented by a health professional.

Because some of the terms used in this workshop are unfamiliar, we have provided a hand-out, "Illnesses in Preschool Children," which staff members may follow as they listen to the presentations. Because the information presented may be unfamiliar, as many visual displays as can be acquired should be used.

For continuity, the two sessions of this module should be given as close together as possible. If an outside consultant is used to make this presentation, it is essential that time be allowed for center staff to share their current policies and procedures for handling ill children with this person.

All of the hand-outs listed in the materials sections which follow are intended to be reproduced and used as part of the workshop presentation.

Agenda

Session I: Common Childhood Diseases
(90 minutes)

10 minutes I. Introduction

20 minutes II. Recognizing ill children
  A. To decide if child is ill
  B. To decide when to call parent
  C. To decide when child may return to the center

30 minutes III. Common rash diseases
  A. Chicken pox
  B. Rubella
  C. Rubeola
  D. Strep throat infection
  E. Scarlet fever
  F. Impetigo

15 minutes IV. Infestations common in preschoolers
  A. Lice
  B. Scabies
  C. Pinworm

15 minutes V. Discussion of specific center problems

Session II: Respiratory Diseases and Common Health Problems
(90 minutes)

5 minutes I. Introduction

25 minutes II. Common ear, nose, and throat problems
  A. Colds
  B. Viral respiratory "flu"
  C. Ear infection (Acute Otitis Media)
  D. Allergic Rhinitis
  E. Fluid in the ear (Secretory Otitis Media)

25 minutes III. Other health problems common in day care
  A. Fever
  B. Vomiting
  C. Diarrhea
  D. Diaper rash
  E. Bladder infection
  F. Vision impairment

25 minutes IV. Documentation of illnesses in day care
  A. Reporting contagious diseases
  B. Informing parents of illnesses prevalent in the center
  C. Maintaining written records regarding illnesses
  D. Giving and recording medication in the center

10 minutes V. Open discussion

Materials for the Workshop

Displays

1. Sample staff and parent health education cards.

2. Vaughn, Gerald. Mummy I Don't Feel Well. This book has an outdated text but excellent pictures of rash diseases in children.

3. Some Pathological Conditions of the Eye, Ear, and Throat, An Atlas. Abbott Laboratories: North Chicago, Ill., 60064.
   - A. p. 181 "Normal Ear Drum"
   - B. p. 192 "Acute Otitis Media"
   - C. p. 183 "Secretory Otitis Media"
   - D. p. 226 "Scarred Ear Drum"

4. Lice and Scabies, From Infestation to Disinfestation. Reed and Carnrich: Kenilworth, New Jersey, 07033. This is a packet that includes the following brochures:
   - A. "Scabies, Anyone Can Get It"
   - B. "Questions and Answers about Head Lice"
   - C. "What Everyone Should Know about Head Lice"
   - D. "What Does Scabies Look Like?"

5. A sample of the forms used by the local health department for:
   - A. Disease Case Report
   - B. Hearing and Vision Referral

Handouts

1. Common Drugs Given to Preschoolers.

2. Instructions for Preparing Staff and Parent Health Education Cards.

3. How to Take a Temperature.

4. Medical Resources for Young Children model form revised to inform parents and staff of local available care.*

5. Authorization to Administer Medication model form.*

6. Injury/Illness Report model form.*

7. Charts on Illnesses Common in Preschool Children.*

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*These handouts are found in the section of this module, "Model Health Forms for Child Care Centers."

SESSION I

Common Childhood Diseases

I. Introduction

Caregivers in day care must engage in decision-making almost every day regarding the health and well-being of young children. They must be able to observe whether or not a child is ill and decide if it is in the best interest of the ill child and other well children for the child to remain at the center. They must decide when a parent should be called from work or school to attend a sick child, and when they must call a physician or emergency room for immediate medical advice.

The goals of this workshop are to provide information that will help caregivers recognize when a child is ill and know what to do about it, and to know how to decide when a child is well enough to return to normal activity.

Today we will also talk about some of the contagious illnesses seen in young children. Many of these illnesses have an identifiable skin lesion. Caregivers will learn which of these diseases can be prevented by vaccine, how long they are contagious, and what measures, if any, the center can take to prevent the spread of illnesses.

Parents of well children in the center must be informed whenever one of these contagious illnesses appears in the center. All of these diseases should be reported, by mail, to the local health department.

Questions or discussion about specific children or incidents relevant to issues presented today are encouraged.

II. Recognizing Ill Children

A. To decide if a child is ill, watch for the following:

1. A change in behavior: a happy, active child is listless, tired, irritable, refuses to play. This is the most common indication of illness and may be the only obvious symptom.

2. Fever: a child may have bright red cheeks or "glassy" eyes. A child's temperature can be checked by using a Clinitemp Strip (available from Clinitemp Inc., Indianapolis, Indiana, 46268) or a thermometer. An article in the Appendix describes how to read a thermometer.

3. Pain:

    a. A child may signal pain nonverbally by:
        1) Crying
        2) Pulling at her ear
        3) Refusing to drink juice
        4) Pulling her knees up to her abdomen
    b. Or verbally by:
        1) Saying her stomach hurts (most preschool children will say "stomach" meaning somewhere in the lower chest and abdominal area).
        2) Saying, e.g., "It hurts to talk," "It hurts to run."

4. Symptoms related to nose, throat and chest illness:

    a. Sneezing and watery eyes
    b. Runny nose
    c. Coughing
    d. Breathing noisily

5. Symptoms related to stomach and intestinal illness:

    a. Refusing food
    b. Vomiting
    c. Diarrhea

6. A change in body movement: a child who normally can run, does not, a right-handed child uses only her left hand.

7. Rash: any rash should be considered a signal of illness unless proven otherwise. Check for rashes on the face, chest, abdomen, and insides of arms.

8. Stiff neck: if a child has a fever, is irritable or listless, either ask the child to touch her chin to her chest or gently do it for her. If a chin can be pressed towards the chest without discomfort a stiff neck is usually not present.

B. To decide when to call parent and/or child's physician:

1. Gather all the information you can first, before calling. Ask the following questions:

    a. Is there a fever of 101 degrees or higher?
    b. Is there any unexplained skin rash?
    c. Is there any indication of ear pain or abdominal pain?
    d. Do you think the child has difficulty swallowing? Breathing?
    e. Do you think the child's eyes look "gooey" or do they have a yellow discharge?
    f. Have you checked for a stiff neck?
    g. If the child will allow, have you looked at her throat with a flashlight to see if the tonsils look bright red or have white spots on them?
    h. Has the child had vomiting or diarrhea two times or more?

2. If any of the above symptoms are present alone, or with cold symptoms (sneezing, coughing, scratchy throat), the parent should be called. The parent should be advised to:

    a. Take the ill child home and/or
    b. Seek the advice of the child's physician.

3. If a parent cannot be reached, the director may elect to call the child's physician directly for advice.

C. A child is well enough to return to day care when:

1. A contagious disease is no longer communicable. (Appendix C describes this stage for specific illnesses.) Two examples are: chicken pox is no longer contagious after the lesions have crusted over, and a "strep" throat is no longer contagious after four doses of antibiotic have been given.

2. Any fever has been gone for 24 hours.

3. The child feels well.

4. The child on a ten-day antibiotic regimen for infection has no fever and feels well. (However, this child should not be in the center if her physician specifically recommends that she not attend.)

III. Common Rash Diseases

A. Chicken Pox

1. A viral illness. There is no vaccine to prevent it.
2. A highly contagious, but generally a mild illness.
3. The rash is described as a small, red elevation containing pus. Usually cold symptoms precede the rash by two days.
4. Until all lesions are crusted over, chicken pox is contagious; lesions generally require a week to crust over.
5. The rash often begins on the head, so it is easily missed the first day.
6. Chicken pox should be reported to the health department by mail.
7. The common problem children experience with chicken pox is intense itching. Scratching may infect a lesion and cause consequent scarring.

B. Rubella (German Measles)

1. A viral illness prevented by a vaccine which is usually given at age fifteen months.
2. Generally a mild illness in young children. However, because of the large number of child-bearing-age females who work in day care, any case of Rubella requires:
    a. Calling all women who worked in the center within 21 days (incubation period) and telling them Rubella has been diagnosed in a child at the center.
    b. Advising all women in the day care operation who could be pregnant to call their physician if they think there is any chance they are exposed to rubella.

3. The rash is fine, pink, and flat, appearing first on the face and arms, then on the chest and abdomen. The rash is preceded by cold symptoms.

4. Measles are contagious for five days after the rash appears.

5. Rubella should be reported to the health department by mail.

C. Rubeola (Red Measles, Hard Measles)

1. A viral illness prevented by a vaccine usually given at age fifteen months.

2. Children ill with rubeola often have a high fever and frequently develop upper respiratory complications like ear infections, bronchitis, or pneumonia.

3. The illness begins with a fever, cold symptoms, and a cough several days before a red-brown rash appears on the face, ears, chest and spreads over the body.

4. It is contagious for five days after the rash appears.

5. Rubeola should be reported to the health department by mail.

[illegible]. Strep Throat Infection

1. This infection cannot be prevented.

2. Strep throat can be a mild illness or a child can be quite ill with fever and a severe sore throat The tonsils may appear red and swollen, and white spots or patches may be seen.

3. The infection is caused by Beta Hemolytic Streptococcus, a bacteria that can be treated with an antibiotic, usually a form of penicillin.

4. The illness is not considered contagious once antibiotic treatment has continued for four doses (or 24 hours).

5. A child may continue in day care while she finishes her antibiotic therapy.

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6. It is essential for adequate treatment of strep infection that the child see a physician, have a throat culture done, and have a prescription written especially for her.

7. Strep throat should be reported to the health department by mail.

E. Scarlet Fever

1. Scarlet fever is strep throat with a rash.

2. The rash is red, occurring first in areas where the skin touches skin, such as under the arm, and it spreads over the body. The rash may take up to six weeks to fade, and the child's skin may peel, especially her face and finger tips. The rash usually appears within 12 hours of sore throat and fever symptoms.

3. Another sign of scarlet fever is a bright red tongue called "Strawberry Tongue."

4. The causes and treatment listed under strep throat (D3 to 7) all apply to scarlet fever.

F. Impetigo

1. Impetigo cannot be prevented by vaccine, but spreading of the disease can be collected by careful handwashing.

2. Usually the child appears well but has weeping lesions on the face, ears, neck, or scalp.

3. The lesion is a red blister filled with straw-colored fluid which crusts over.

4. Impetigo is caused by bacteria, either Staphylococci or Streptococci, and requires a physician to diagnose and prescribe a specific drug for treatment. The child with impetigo may return to day care 24 hours after antibiotic treatment begins.

5. All linens and clothing used by the child should be washed in hot water and disinfectant.

6. Impetigo should be reported to the health department by mail.

IV. Infestations Common in Preschoolers

A. Lice

1. The child will be constantly scratching her head.

2. Small nits can be seen that appear as white dots attached to hair shafts, especially behind the ears and at the base of the skull.

3. The child may not attend day care until she is treated by a physician. The treatment of choice is usually Kwell Shampoo.

4. All washable bedding and clothes should be washed in hot water and disinfectant. All non-washable items should be sprayed with R & C spray. This or any spray should be used away from children, equipment, toys, etc., and should be allowed to air before reuse.

5. A public health nurse should be called to come and check other children in the center, who may not have symptoms, for lice.

B. Scabies

1. The child will experience intense itching, especially at night.

2. Small, pale pink spots can be seen on the skin; most often in the finger webs, neck, elbows, and palms of the hand.

3. Treatment listed for lice (A3 to 5) applies here.

4. The child may continue to itch after treatment, but once treated she may attend day care.

C. Pinworm

1. The child will have itching near the rectum, especially just prior to using the bathroom.

2. Refer the child to a physician who can diagnose and treat her.

3. The child may attend day care 24 hours after medicine is given.

4. All bedding, clothing, and toilet seats should be washed with hot water and disinfectant until 24 hours after medicine is given.

SESSION II

Respiratory Diseases and Common Health Problems

I. Introduction

Today we will continue to discuss some of the common illnesses of childhood and how caregivers in day care can recognize those illnesses, insure proper care for the child, and contain the illness whenever possible.

First we will talk about probably the most common and most troublesome illnesses, those that involve the ear, nose, and throat. We will also discuss illnesses that involve the gastrointestinal system and a general pot pourri of minor illnesses in children.

The presentation also includes methods of record-keeping as part of managing the health care of children. Record-keeping includes reporting communicable diseases to the health department, keeping an illness record at the center, and informing parents about prevalent illness in the center. It also includes methods for giving medicines safely to children. Questions or discussion about specific children or incidents relevant to issues presented are encouraged.

II. Common Ear, Nose, and Throat Problems

A. Colds

1. A viral illness, usually considered contagious for two to three days after the symptoms begin.

2. Basically colds are impossible to control among children in group care because:

    a. Preschool children may get six to twelve colds per year.
    b. Colds are most prevalent between September and April.

3. Whether or not a child is allowed to attend day care with a cold is largely a question of judgment, based on how the child feels.

4. Home and center care of a cold:

    a. Increase liquids, juices, etc.
    b. Use a cold air vaporizer, especially in the area where the child sleeps.
    c. Provide for extra rest.
    d. For a cough, offer a drink of honey, lemon, and water.

B. Viral Respiratory "Flu"

1. Often a specific "flu" will begin to circulate in a center; it will have a collection of similar symptoms. However in general "flu" is suspected when a child:

    a. Has mild sniffling and sneezing
    b. Has a sore throat
    c. Is listless beyond what is usually seen with a cold
    d. Has a headache
    e. Has a fever, followed by a cough which persists

2. "Flu" is considered contagious as long as the fever is present. The child should be excluded from the center.

3. Home and center treatment is as for a cold. The child may return to the center when no fever is present for 24 hours and the child feels well.

4. "Flu" has the potential for repiratory complications like bronchitis and pneumonia. Any child with flu symptoms should be referred to a physician if:

    a. The fever is greater than 102 degrees
    b. Fever lasts longer than two days
    c. The child has a persistant cough
    d. The child has difficulty in breathing

C. Ear Infection (Acute Otitis Media)

1. An ear infection is not a contagious illness. It may follow a cold or flu or develop spontaneously.

2. Ear infections tend to occur in the same child repeatedly, and with similar symptoms. Some general "clues" that indicate a possible ear infection are:

   a. Fussiness
   b. "Gooey" eyes or yellow discharge around the eyes
   c. Fever may or may not occur
   d. Infant or toddler may pull at her ear and/or cry
   e. Preschoolers may complain of earache
   f. The caregiver may note the child does not seem to hear well
   g. The ear drum may rupture, in which case a yellow discharge may be seen on the pillow at nap time.
      1) Acute Otitis Media is a self-limiting disease, i.e., when the infection is untreated, the ear drum will rupture.
      2) A ruptured ear drum may result in scarring and some degree of hearing loss.

3. There is no home treatment for an ear infection. An ear infection is caused by one of several bacterial agents, and must be diagnosed and treated by a physician. Usually the treatment is an antibiotic given by mouth for ten days. Often the child is reexamined after antibiotic therapy to be sure the infection is cleared up.

4. Whether or not a child attends day care depends entirely on how she feels. Other children in the center are not affected.

D. Allergic Rhinitis

1. The child with allergic rhinitis has a chronic stuffy or runny nose. Although she appears to have a chronic "cold," she does not have a contagious illness.

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2. Observations a caregiver can make that suggest an allergic condition rather than a cold or flu are:

   a. The child has cold symptoms, without fever, that persist beyond a week.
   b. The child may rub her nose and push the palm of her hand against the end of her nose in an upward fashion in the "allergic salute."

c. The child may appear to have chronic bluish circles under her eyes.

3. When the above observations are made, caregivers should share them with the parent and encourage the parents to seek the advice of a phsyician regarding these symptoms, if they have not already done so. A physician may:

   a. Suggest a medication to control symptoms
   b. Determine the child has mild allergic symptoms and do nothing
   c. Suggest a complete allergy evaluation (usually not until the child is over five)
   d. Decide the problem is something else altogether.

4. When a child is known to have allergic rhinitis, the caregiver should consider the following questions:

   a. "Do I think this child hears well?"
      1) "Does she ignore me when I call her?"
      2) "Does she constantly say, 'what?'"
      3) "Does she talk in a loud tone of voice?"
      4) "Does she turn record players, etc., on the highest volume?"
   b. Share any positive observations with the parent.
   c. Arrange to have a hearing screen done for this child.

5. Teach the child how to wipe, not blow, her chronic runny nose and how to use a tissue properly.

E. Fluid in the Ear (Secretory Otitis Media) "Glue Ear"

1. Fluid in the ear can occur following an ear infection, or can be seen concurrent with allergic rhinitis, or colds.

2. This condition can only be diagnosed by a trained examiner who looks directly at the ear drum. Fluid partially fills the middle ear and interferes with the normal process of hearing. A caregiver may suspect "fluid in the ear" when a child is recovering from an ear infection or is known to have allergic rhinitis and:

   a. A hearing loss is noted by the parent or caregiver.
   b. The child complains of a pressure sensation in the ear which she may call an "earache."
   c. The child complains her ears are "popping."

    d. The child notes she cannot hear on the telephone.
    d. The child will always turn her head to the same side when listening.

3. The child should be referred to a physician, either a pediatrician or an ear, nose and throat doctor (Otologist). Treatment is usually drug therapy first and if that is not successful, tympanostomy "tubes" are inserted into the ear drums. This is a surgical procedure that often improves the hearing loss and reduces the number of ear infections. When a child has tubes inserted, a caregiver must find out and record any restrictions in activity.

4. An effective way to ensure the child's adequate treatment when hearing loss is suspected is to have a hearing screen done (Audiogram). This adds a concrete piece of evidence to other observations made by the caregiver.

III. Other Health Problems Common in Day Care

A. Fever

1. Ranges:
    - a. 100 degrees or less is within the normal range
    - b. 101 degrees to 103 degrees is a moderate fever
    - c. 103 degrees to 105 degrees is a high fever

2. Treatment for a moderate fever:
    - a. Call the parent
    - b. Remove the child's outer clothing
    - c. Keep the child quiet
    - d. If the parent has left signed permission, give aspirin or Tylenol. (Some day care centers have an aspirin policy--a presigned permission to give aspirin when a child's temperature reaches a certain point, usually 101 degrees.)

3. Treatment for a high fever:
    - a. Follow steps a,b,c,d above.
    - b. If a parent cannot immediately be reached, call the child's physician, the local pediatric walk-in clinic, or the emergency room and follow instructions given over the phone.

B. Vomiting

1. Vomiting is often a gastro-intestinal "flu."

2. If viral "flu," it is a communicable illness.

3. It usually lasts three to six hours.

4. The child should not remain at the center while she is symptomatic (has vomited two or more times).

5. Home or center treatment of vomiting:

   a. Give nothing for three hours, then
   b. Give a small (1/2-ounce) amount of water, flat coke, ginger ale, Gatorade, or Kool-aid. If the child keeps this liquid down for an hour, offer one ounce, if that stays down continue to give small amounts (2 to 4 ounces) of the above liquids every hour.
   c. If vomiting recurs, wait two hours and try step b again.
   d. If vomiting continues more than 12 hours; or if vomiting is green, bloody or accompanied by a fever at 101 degrees or over; the child should be referred to a physician.
   e. Staff attending the child should practice careful handwash techniques.

C. Diarrhea

1. Diarrhea is produced by an overactive bowel; stools are runny and watery.

   a. Mild diarrhea: up to four runny stolls a day
   b. Moderate to severe diarrhea: 4 to 10 runny stools a day

2. Diarrhea is commonly caused by a virus. Diarrhea may occur without vomiting or may follow vomiting.

3. It may last several days.

4. Mild diarrhea can usually be managed in a day care center. Moderate to severe diarrhea is not a manageable illness in day care.

5. Home or center treatment of diarrhea:

   a. Offer small amounts of water, weak tea with sugar, Kool-aid, popsicles, jello water (1 box to four cups of water), or flat ginger ale.
   b. After 24 hours skim milk can be added if diarrhea is lessening.
   c. After two days, a bland diet can be given until the stool returns to normal.
      1) A bland diet contains applesauce, bananas, other soft fruits; potatoes; oatmeal; noodles; puffed rice cereal; and scrambled eggs.
      2) A bland diet should avoid hard fruits, vegetables, graham crackers, bran cereals, whole wheat, spices, and fatty foods.
   d. Or, follow the specific instructions given by the parent or the child's physician.

6. If diarrhea is greater than 10 stools a day, accompanied by fever, or is bloody, the child should be referred to a physician.

7. Staff attending the child should practice careful handwash techniques.

D. Diaper Rash

1. Diaper rash is any red, raw-looking rash in the diaper area.

2. It can be caused by sensitivity to fabrics or detergents, a fungus infection like Monilia, or a bacterial infection.

3. Home or center treatment of diaper rash:

   a. Switch diapers currently in use (e.g., switch from disposable to cloth or vice versa or switch brands of disposables).
   b. If cloth diapers are used, switch detergents and delete fabric softeners.
   c. Do not use rubber or plastic pants.
   d. Remove the child's diapers and cleanse the affected area and allow to air dry for 20 minutes at a time four times a day.
   e. Cleanse the diapered area meticulously with plain water and cotton balls and allow it to dry thoroughly before rediapering.
   f. After cleansing, apply an ointment such as Desitin or A & D ointment.

g. If all the above measures fail, refer the child to a phsyician who can determine if the diaper rash is caused by some infective agent. If so, a prescription ointment is required in addition to the above measures.

4. Always wash hands before and after diapering.

E. Bladder Infection

1. A Bladder infection is not uncommon in female children. Bladder infection should be suspected whenever a girl has an undiagnosed fever.

2. Other symptoms are frequency of urination, urinating small amounts at a time, a burning sensation, or a "fishy" smell to the urine.

3. Whenever a bladder infection is suspected, the child should be referred to a physician. Diagnosis can only be made if a urinalysis is done; proper treatment involves specific drug therapy.

4. The day care center staff can assist in preventing a bladder infection by:

    a. Encouraging frequent emptying of the bladder (every two hours).
    b. Increasing fluid intake.
    c. Teaching girls to wipe from front to back.

F. Vision Impairment

1. Caregivers are in a position to notice possible vision impairment in preschoolers. They might observe:

    a. The child constantly bumps into objects.
    b. The child holds a book closer than four to six inches from her face.
    c. The child cocks her head to the right or left rather than looking straight ahead.
    d. One of the child's eyes deviates to the right or left.
    e. The child has competent fine motor skills for her age but has difficulty with large motor skills.
    f. There is a history of family eye disease.

2. Vision screening is usually available for children age three or older; however any child, no matter how young, can be examined if needed.

   a. Children whom you suspect may have a vision problem and are under three should be referred to an Ophthymologist, a physician who specializes in eye care.
   b. Children whom you suspect may have a vision problem and are three or over, should have a vision screen done. Screening can usually be arranged through the local health department.

IV. Documentation of Illnesses in Day Care

A. Reporting Contagious Diseases:
Reporting contagious illnesses in group care settings is requested by local health departments. Mail-in cards listing the specific illnesses of concern are available from the local health department office.

B. Informing Parents of Illnesses Prevalent in the Center:
Parents must be informed of all contagious diseases present in the center. One recommendation is to prepare and use the parent health education cards described in the Resources section of this module.

C. Maintaining Written Records Regarding Illnesses:
A written record of illnesses in the center must be maintained. This record can be kept as a log, or in individual children's folders, but should always include the following: name, date, symptoms, care given if any.

D. Giving and Recording Medication in the Center:
A specific policy regarding giving medication to children should include the following:

1. The center should administer only prescription medications and children's aspirin or aspirin-substitute.

2. A parent or guardian's written permission must be obtained before medicine is given.

3. All prescription medication should be in the original container, stored according to instruction, labelled with the specific child's name, medication name and dosage strength along with instructions for use. The prescription must be current.

4. Each dose of medication should be recorded with the time and the amount given or applied.

5. The first dose of any medication may not be given by any day care personnel.

6. Medicine will be stored in a locked cabinet or locked box in the refrigerator.

7. All prescription medication shall be returned to the parent or destroyed when no longer needed by the child.

RESOURCES

Common Drugs Given to Preschool Children

Caregivers may be required to administer medicine to children, given written parental permission. It seems important for caregivers to know the usual medication dosage for different ages and some of the more common side effects of medications. Complete information about most drugs can be found in the Physician's Desk Reference. However, this book is not readily available to day care centers (it may be purchased in book stores for about $12 or $13), nor is it easily interpreted by lay persons. A specific concern about any drug being administered to a child in day care should be referred to the physician who prescribed the drug or the pharmacist who prepared the prescription.

The following information is not an endorsement of specific drugs but simply a way of providing caregivers with information about some of the drugs they may be administering to children.

I. For Allergic Rhinitis and Serous Otitis Symptoms

A. Actifed

A combined antihistamine and decongestant. Prepared as a yellow syrup for children. Usual dose: One teaspoon three times a day. Side effects: Drowsiness or stimulation.

B. Benadryl

A potent antihistamine. Prepared as a red liquid for children. It is used for allergic reactions like hives but never for asthma attacks. Usual dose: One teaspoon three to four times a day. Side affects: drowsiness, confusion, restlessness, nausea, vomiting, diarrhea, nasal stuffiness.

C. DimeTapp

A combined antihistamine and decongestant. Prepared as a purple syrup for children. Usual dose: Ages two to four, 2/3-teaspoon three or four times a day. Ages four to twelve, one teaspoon three or four times a day. Side effects: skin rashes, drowsiness, increased irritability or excitement.

II. For Control of Bronchial Wheezing

A. Elixophyllin

Relieves bronchial spasm. Usual dose: based on body weight. Side effects: restlessness, insomnia, fast heartbeat; many others including GI tract symptoms. Overdosage: can cause headache, agitation, and convulsions.

B. Quibron

Relieves bronchial spasm; contains same drug as Elixophyllin plus an expectorant. Usual dose: based on body weight, Side effects: essentially same as Elixophyllin. Overdosage: central nervous system stimulation including convulsions.

III. For Reducing Fever and Relieving Pain

A. Acetaminophen

Comes as Liquiprin, Tempra, Tylenol, Datril. Tylenol is probably the most frequently used among preschoolers. Prepared as fruit-flavored tablets or red liquid. Usual dosage: Tylenol liquid--one to three years, 1/2-teaspoon three to four times daily; four to five years, one teaspoon three to four times daily. Usual dosage: Tylenol tablets--age three, one tablet; four to five years, two tablets. Side effects: jaundice, liver involvement.

B. Aspirin

Most commonly prepared for children as orange-flavored, chewable tablets, 1-and-1/4-grain per tablet. Usual dosage: rule of thumb--one grain for each year of age. Age one--one tablet; two to three years--two tablets; four to five years--three tablets. CAUTION: Do not give to asthmatic children. Always ask parent how much aspirin was given during the night and when the last dose was given. Aspirin should always be given with a full glass of water. Aspirin should not be given more than five times in 24 hours. Side effects: gastritis, tinnitis, GI bleeding.

IV. For Diaper Rash

A. Desitin

A zinc oxide-base ointment with vitamins A and D, and cod liver oil added. Usual dose: apply to diaper area three times a day on clean, dry surface.

B. Mycolog

An ointment containing Nystatin, a drug that is effective against Mo[illegible]al (yeast) infections. Usual dose: apply to diap[illegible]a three times a day. Avoid prolonged use.

NOT FOR PARENTS ONLY *

The What, Why, When and Where of Home Management of Common Childhood Problems

Janet Reynolds, R.N., B.S.N., P.N.P.

Ms. Reynolds, R.N., B.S.N. (Florida State University, Tallahassee), P.N.P. (Medical College of Virginia, Richmond).

HOW TO TAKE A TEMPERATURE

Oral (By Mouth)

1. Shake the thermometer until the mercury is below the 95 degree mark. Firmly hold the non-bulb end of the thermometer and briskly snap the hand at the wrist. This action moves the mercury toward the bulb end.
2. Place the bulb under the right side of the child's tongue. (Right side of tongue is used so that bulb is placed closely to the sublingual artery). Have him close his mouth. Children under 5 years of age may have difficulty with this.
3. Leave the thermometer under the tongue for at least 3 to 5 minutes.
4. After use, wash thermometer with soap and tepid water, rinse with alcohol and store safely.

Rectal (By Rectum)

1. Rectal temperatures should be taken on small children under 3 years old. This is the most accurate method of taking a temperature.
2. Shake the rectal thermometer until the mercury is below the 95 degree mark.
3. Lubricate the bulb with Vaseline® or K-Y jelly®. This helps ease the insertion and prevents trauma to the rectum. The bulb should be inserted into the rectum until fully covered or about ¼ to ½ inch.
4. Hold thermometer in place for 1 to 3 minutes. Never leave a child alone with a rectal thermometer inserted. There is a natural tendency by the child to expel the thermometer. Babies usually have a bowel movement after having a rectal temperature taken.

Axillary (Under Arm)

1. This method of taking a temperature is the least accurate, but least traumatic to a child. You can use an oral or rectal thermometer.
2. Shake thermometer until the mercury is below the 95 degree mark.
3. Place the bulb under the arm, well up into the armpit. Leave in place for 10 minutes. It may be necessary for you to hold the child's arm down if he is uncooperative.

Centigrade and Fahrenheit Temperature Equivalents

C°	F°
0	32
35	95
36	96^{8}
37	98^{6}
38	100^{4}
39	102^{2}
40	104
41	105^{8}
42	107^{6}

To Convert
C° to F° — Multiply By 1.8 and Add 32
F° to C° — Subtract 32 And Divide By 1.8

Temperature Variations

The average normal temperature by mouth is 98.6°F (37°C); by rectum 99.6°F (37.6°C); axillary 97.6°F (36.5°C). During a 24-hour day every individual's body temperature fluctuates. Do not panic if your child's temperature is 1 degree above or below "normal."

Your Child Has A Fever

A fever is a warning of some disturbance of normal bodily processes. It is one of the body's responses to fight infection. In that respect fevers are good, but can be dangerous if they become high. A temperature of 101°F (38^{3}°C) or above should be treated with recommended dosages of fever reducing medications such as acetominophen or aspirin, every 4 to 6 hours. A tub bath with tepid water also helps to bring a fever down. If the fever persists, call your practitioner. Always be prepared to give the practitioner your child's temperature reading anytime he is ill. Feeling your child is not an accurate method of determining if your child has a fever.

Thermometer Uses

The most important use of a thermometer is to take your child's temperature. Thermometers are also helpful in other ways. To help a baby expel gas or pass a difficult stool, gently insert the lubricated thermometer ½ inch into the rectum. This may provide enough dilation of the rectum to allow relief.

References

1. Bergeson PS, Steinfield HJ: How Dependable is Palpation as a Screening Method for Fever?, Clinical Pediatrics 13:350-351, (April) 1974.
2. Marlow DR: Textbook of Pediatric Nursing, 4th Ed. Philadelphia, W. B. Saunders Company, 1973.
3. Red Cross: Your Thermometer Guide.

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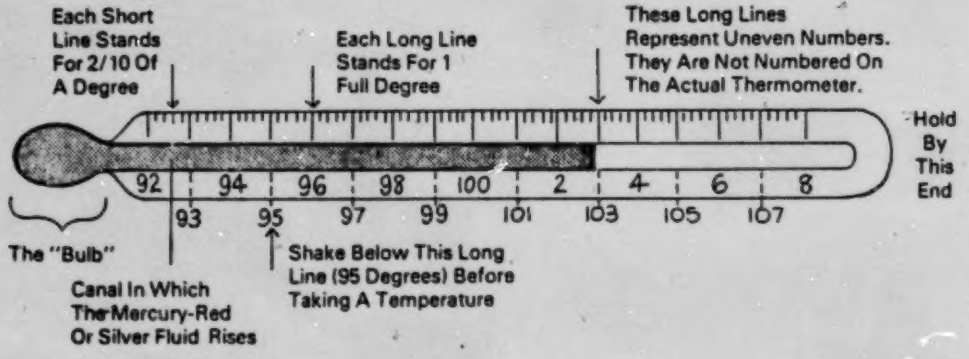
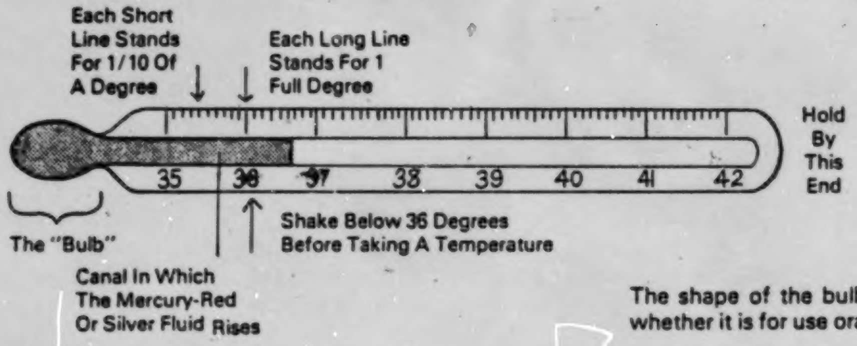
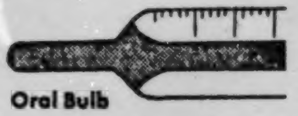
A GUIDE TO THERMOMETERS AND TEMPERATURES

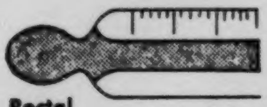
Fahrenheit Thermometer


Each Short Line Stands For 2/10 Of A Degree
Each Long Line Stands For 1 Full Degree
These Long Lines Represent Uneven Numbers. They Are Not Numbered On The Actual Thermometer.
92
94
96
98
100
2
4
6
8
93
95
97
99
101
103
105
107
Hold By This End
The "Bulb"
Canal In Which The Mercury-Red Or Silver Fluid Rises
Shake Below This Long Line (95 Degrees) Before Taking A Temperature

Centigrade Thermometer


Each Short Line Stands For 1/10 Of A Degree
Each Long Line Stands For 1 Full Degree
35
36
37
38
39
40
41
42
Hold By This End
The "Bulb"
Canal In Which The Mercury-Red Or Silver Fluid Rises
Shake Below 36 Degrees Before Taking A Temperature

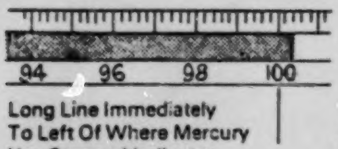




The shape of the bulb of your thermometer identifies whether it is for use orally or rectally.

HOW TO READ A THERMOMETER

Fahrenheit

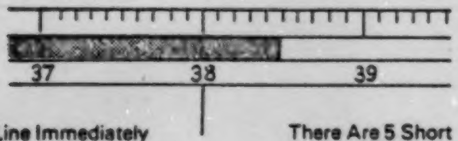


Long Line Immediately To Left Of Where Mercury Has Stopped Indicates 100 Degrees

There Are 2 Short Lines, Each Indicating 2/10 Of A Degree Between 100 And Where The Mercury Stopped. These 2 Short Lines Stand For 4/10 Of A Degree

1. Hold the thermometer in good light to read. Be sure the light is in back of you. Do not hold at the bulb end.
2. Locate where the mercury has stopped in the canal of the thermometer.
3. Read the long line immediately left of where the mercury stopped. This will give you the full degree. (38)
4. Count the short lines between the long line you have just read and the point where the mercury has stopped. Each short line stands for 1/10 of a degree.
5. Add the short lines (5/10) to the long line (38) and the temperature reading is 38.5 degrees.

Centigrade



Long Line Immediately To Left Of Where Mercury Has Stopped Indicates 38 Degrees

There Are 5 Short Lines, Each Indicating 1/10 Of A Degree Between 38 And Where The Mercury Stopped. These 5 Short Lines Stand For 5/10 Of A Degree

1. Hold the thermometer in good light to read. Be sure the light is in back of you. Do not hold at the bulb end.
2. Locate where the mercury has stopped in the canal of the thermometer.
3. Read the long line immediately left of where the mercury stopped. This will give you the full degree. (100)
4. Count the short lines between the long line you have just read and the point where the mercury has stopped. Each short line stands for 2/10 of a degree.
5. Add the short lines (4/10) to the long line (100) and the temperature reading is 100.4 degrees.

Instructions for Preparing Staff and Parent Health Education Cards

In order to assist day care staff in recognizing and controlling communicable diseases that most often occur in day care centers, a card can be prepared for each disease that provides basic information and a photograph depicting the specific lesion or observable diagnostic symptom. A sample is displayed below:

Chicken Pox

Early Symptoms: May or may not feel well, decreased appetite, runny nose. Fever may or may not be present or may occur with rash.

Cause/Incubation: Virus 10 - 21 days, usually 14 days.

Communicability: 1 - 2 days before onset to 5 - 6 days after skin lesions appear or until all lesions are scabbed over. Spreads from direct contact, respiratory droplets or airborne transmission.

Description: Rash has "Dew Drop or Rose Petal" appearance. Progresses to small elevations containing pus.

Prevention: None .

Control/Relief: Articles soiled by discharge should be washed in hot water and disinfectant. Child should wear cool, light weight clothing. Fingernails cut short. Wash hands frequently. Bathe frequently to avoid infection. Calamine lotion or baking soda baths help ease itching. If fever occurs, treat with aspirin or Tylenol (dose for age group) and bed rest. If problems arise, see a doctor.

The information can be typed on 9 x 6 index cards and a colored photograph of the disease can be attached to the left-hand corner. The card can then be covered in clear contact paper.

The illnesses selected for these health education cards were: Hard Measles, German Measles, Chicken Pox, Roseola, Impetigo, Pink Eye, Scarlet Fever, Strep Throat, Mumps, Scabies, Lice, and Pinworm.

Technical information for these cards can be found in the section on "Common Childhood Illnesses" and in Benenson and Abram, Control of Communicable Diseases in Man, 12th ed., 1975.

The cards seemed most useful to day care staff and parents when they included a colored photograph. Colored photographs of childhood communicable diseases were obtained by writing to the health education departments of pharmaceutical companies.

Pictures of Scarlet Fever, Hard Measles, Chicken Pox, German Measles, and Roseola were obtained for use with permission from Ross Laboratories, Nursing Education Aids, Columbus, Ohio 43216.

Pictures of Pink Eye and Impetigo were obtained for use with permission from "Common Skin Diseases," Professional Relations Department, Abbot Laboratories, Abbot Park, North Chicago, Ill. 60064.

Pictures of Strep Throat were obtained from booklets "Streptococcal Sore Throat" and "Rheumatic Fever," for use with permission from Wyeth Laboratories, P.O. Box 8299, Philadelphia, Pa. 19101.

Pictures of lice and pinworm were hand drawn.

A local Public Health nurse or health department health educator would be a good resource for obtaining health education brochures.

Follow-Up Suggestions for the Trainer

Present the Mini-First-Aid Module.

Consult to further discuss medicine storage, medicine permission forms, and recording of medicine given in a center.

Consult to develop a parent-informing health education system regarding communicable diseases.

Consult to review materials and space used to care for mildly ill children

Consult to develop an individual health care plan for a child with a chronic health problem.

Consult to help develop a health curriculum unit to teach preventive health.

Organize a parent meeting to discuss, "How to Decide When a Child Should Not Attend Day Care"; "How to Decide When a Child is Well Enough to Return."

Consult to develop a health resource system which is best suited to the children enrolled in the center.

Consult to look over the center's health recording system and to discuss implementing an individual record-keeping system.

Consult to review or construct a written health policy that provides for preventive health measures as well as details procedures for admission to center, and caring for ill or injured children.

Mini-First Aid

Lynn Collins Clarke
Marcia Van Fossen

PREPARING THE WORKSHOP

Workshop Objectives

1. To provide caregivers information about emergency treatment for children of preschool age who encounter mishap or injury on center premises.
2. To provide specific knowledge about emergency care for choking, by using a film demonstrating the accepted technique for assisting a choking victim, and providing opportunity for practice.
3. To provide caregivers with a suggested policy for handling an emergency situation that occurs on-site.
4. To provide caregivers with a suggested policy for handling an emergency on field trips (off-site).
5. To provide caregivers with opportunity to discuss methods of written communication that facilitate management of accidents, and injuries and provide adequate parent education.
6. To provide ideas for caregivers to incorporate into health policies thay may help to prevent accidents or injuries and/or provide proper care.

Method of Delivery

This workshop module was developed to help day care center employees recognize and offer first aid for accidents they are likely to encounter with preschool children. It is not considered a substitute for the more complete first aid and cardiac-pulmonary resuscitation (CPR) courses offered by the Red Cross and other organizations. The module was designed originally as a 90-minute presentation followed by questions, answers, and a demonstration. This was tried in several centers, always with the same result: there was too much material for the time allotted. Therefore, we recommend dividing the contents into two 90-minute presentations. These could be given on successive weeks to facilitate continuity. Depending on the size of the audience, it is recommended that questions and the spontaneous sharing of ideas be encouraged throughout the presentation.

Agenda

Session I: An Overview of First Aid
(90 minutes)

5 minutes	I.	Introduction
10 minutes	II.	Psychological Reactions To Emergency
30 minutes	III.	Assessing an Emergency A. What to Do for an Already-Injured Child B. What to Do for an On-Site Injury C. What to Do for an Off-Site Injury
	IV.	Recording Injuries and Illness
30 minutes	V.	Choking Film Presentation and Demonstration
15 minutes	VI.	Large Group Sharing; Questions and Answers

Session II: Treating Specific Injuries
(90 minutes)

5 minutes	I.	Introduction
35 minutes	II.	Specific *Minor* Emergencies A. Lumps and Bumps B. Scratches C. Splinters D. Bites E. Stings F. Nosebleeds G. Tooth displacement

40 minutes III. Specific Major Emergencies

- A. Shock
- B. Poisonings
- C. Burns
- D. Broken Bones
- E. Sprains
- F. Severe Cuts
- G. Significant Head Injury
- H. First Convulsion

10 minutes IV. Large Group Sharing; Questions and Answers

Materials for the Workshop

Displays

1. Outside Resource Materials:
    - A. American Red Cross Printed Materials
    - B. Multi-Media Standard First Aid Modules
    - C. Home & Safety Course for Primary Grades
    - D. Home Emergencies--What To Do
    - E. Community Education & Health Courses
    - F. First Aid for Foreign Body Obstruction
    - G. Upjohn Co., "Antidote & First Aid for Poisoning"
    - H. Child Care Organization Accident or Illness Report (DSS Form 3311)
    - I. Holbster-Steer Laboratories, "Insect Sting Emergency Kit" Downers Grove, Ill. 60075

2. First Aid Kit: Made using Red Cross Instructions given in Appendix L.

3. Assorted books from the bibliography

Handouts

1. American Red Cross Printed Material (free of charge):
    - A. First Aid for Choking (poster)
    - B. House Plants Replace Aspirin as Top Poison Agent
    - C. Frequently Ingested Common Household Items
    - D. Practice Poison Prevention & Live
    - E. Continuous Cycle of Traumatic Shock
    - F. An Inexpensive First Aid Kit
    - G. Some Parental Guides for Child Safety
    - H. CPR Saves Lives
    - I. First Aid for Poisonings
    - J. First Aid for Snake Bites

2. Project-Developed Materials:

    - A. Assessing an Emergency (page 41)
    - B. What to Do in Case of a Serious Injury at the Center (Appendix F)
    - C. Field Trips (Appendix L)
    - D. Shock
    - E. Injury/Illness Report Model Form (Appendix E)

Film

"Choking, To Save a Life" (Courtesy of the American Red Cross).

This 12-minute, color, sound, 16mm film was designed for the lay public. It demonstrates the back blow and abdominal thrust techniques used to help choking victims, adult or child, in a conscious or unconscious state. The film also explains how to recognize if these procedures are necessary and describes the universal choking signs.

This is an excellent basic resource which is self-explanatory.

The choking film is included in the CPR course given by the American Red Cross. These courses run approximately nine hours. A suggestion would be to request a certified CPR instructor from a local chapter to present the film and demonstrate for a portion of the first session.

Another suggestion would be to hold CPR classes at the center. The time could be divided into three 3-hour sessions on successive days. Ideally, for the convenience of day care staff, it might be possible to divide the hours into four 2-hour segments for one week. These could be held at nap time. Some CPR instructors are willing to do this. The advantage of this method would be that staff could receive certification in CPR. Renewal certification could be scheduled by holding a 3-hour session within the year at the center.

Other

1. Projector
2. Infant Manikin
3. Masking Tape

SESSION I

An Overview of First Aid

I. Introduction

This presentation is in no way intended to usurp standardized First Aid or Cardiac-Pulmonary Resuscitation Courses offered by the American Red Cross or other organizations. It is called Mini-First Aid because it reviews specific components of first aid, as defined by the American National Red Cross, that are:

1. Likely to occur in toddler and preschool age children and are
2. Likely to occur in day care center settings.

Prevention is the best defense against childhood accidents. However, you all know that accidents are the major source of injury, and in fact, the leading cause of death in children, so you must also know how to deal with accidents when they occur.

Children are more likely to have serious accidents than adults. Their natural curiosity to test all limits, to attempt to master new physical skills, and to thoroughly explore their environment plus their lack of understanding about danger makes them accident-prone.

Even in the best-supervised situation accidents do occur. Therefore, adults responsible for the care of young children should know how to respond quickly and appropriately in emergency situations to help prevent these injuries from becoming worse. Every center should have some provisions or requirements for staff training in first aid.

The basic purpose of First Aid always is to preserve the child's life and to prevent further physical and psychological injury until help arrives, whether the accident occurs in the center or out of the center. It's important for the provider of aid to keep calm to accomplish these goals.

This session will discuss how to manage an emergency situation whether it occurs in the center or on a field trip. A film demonstrating aid for a choking victim will follow. Afterwards, the techniques discussed can be practiced by all of us on the infant manikin.

It is important to remember that anyone involved with an accident--the victim, the provider of First Aid, or observers--have a physiological reaction to the situation. These symptoms are explained in the first handout which was adapted from a Red Cross handout entitled, "The Victim's Psychological Reaction to Emergency." When providing aid one must remember these reactions, respect the feelings of the victim, and understand the victim's limits. Also, keep in mind the feelings of the children observing. Experiences children have at this age influence their ability to handle situations in the future.

II. The Victim's Psychological Reaction to Emergency*

A. Basically there are five types of reactions to danger. Victims may exhibit more than one type of reaction either simultaneously or in successive stages.

1. Normal Reaction
    - a. Excessive perspiration
    - b. Weakness and nausea
    - c. Trembling
    - d. Difficulty in thinking clearly
2. Individual Panic Reaction
    - a. Blindness to reality
    - b. Pointless physical activity (hysteria). (Infrequent but very dangerous as it may result in self-destruction or mass panic.)
3. Depressed Reaction
    - a. Numbed and confused
    - b. Puzzled or preoccupied with incident
    - c. Vacant gaze
    - d. May not respond when spoken to
    - e. May seem unaware of surroundings
4. Overactive Reaction
    - a. Explosion of activity
    - b. Unreal confidence in abilities
    - c. Intolerant
    - d. Interferes with effective leadership of other
5. Bodily Reaction
    - a. Severe nausea and vomiting
    - b. "Conversion Hysteria": victim unconsciously converts fear into a strong belief that some part of her body has ceased to function; she may not be able to see, hear, speak, or move: her disability is real.

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*Adapted from "Psychological Reactions," prepared by the American Red Cross.

B. There are four basic principles to remember in dealing with psychological reactions:

   1. Accept every person's right to her own feelings.

   2. Accept every person's limitations.

   3. Size up a disturbed person's abilities as accurately and quickly as possible.

   4. Accept your own limitations in a relief role.

C. The following are some ways to handle reactions for each of the above reaction categories. These reactions may occur in any type of illness or injury.

   1. Normal Reaction

      a. Little help needed.
      b. Offer sympathy and encouragement.
      c. Remember the victim may hear but not be able to decode messages.

   2. Individual Panic Reaction

      a. Early separation and control of the victim is urgent.
      b. First try gentle firmness and kindness (it will be difficult to obtain the victim's attention).
      c. As a last resort, with at least two or three assistants, firmly and gently restrain the victim (generally, after 5-10 minutes of restraint the victim will calm down; as she becomes more responsive make simple statements about what she may do).

   3. Depressed Reaction

      Suggest the child perform simple routine jobs. Children will reflect the attitudes of the adults around them.

   4. Overactive Reaction

      a. The victim needs physical activity.
      b. Be tactful, they may be intolerant of others' ideas.

   5. Bodily Reaction

      a. Find small jobs the child can do in spite of her symptoms.
      b. Make her feel you are interested in her.

III. Assessing an Emergency

A. What to do if you do not witness an accident but find a child already injured or unconscious.

1. STAY CALM.

2. DO NOT MOVE the injured child.

3. a. CHECK THE PULSE.
   b. CHECK THE BREATHING AND AIRWAY. } If absent, do CPR--WHERE INDICATED
   Place your cheek next to the victim's mouth to feel for air exchange. Also look to see if the victim's chest is rising and falling. If not, open her mouth and check for obstructions. Follow recommendations given by the American Red Cross in their film, "Choking, To Save a Life," or do CPR where indicated.
   c. CHECK FOR BLEEDING.
   d. LOOK for signs of burns or stains around the mouth or for any clues such as an empty pill bottle, etc., that might suggest poisoning.

4. If serious injury suspected, TREAT FOR SHOCK.

5. GET HELP from another adult who can call the doctor or the Poison Control Center for medical advice by telephone, or the 911 Emergency for direct care.

B. What to Do in Case of a Serious Injury at the Center:

1. Follow First Aid instructions for the specific type of injury.

2. Get help from another adult who can assist you (the director or a teacher).

3. While first aid is in process, get the child's emergency card from the office.

4. Notify the parent, or failing that, the child's physician or the nearest emergency room.

5. Arrange transportation; this can be a staff car, parents's car, or 911 vehicle--as need determines.

6. Accompany the child as needed (two adults to one child). Do not send one parent and the seriously injured child alone to the Emergency Room. You may determine the best action is to meet the parent at the Emergency Room.

7. Choose the nearest hospital for all serious injuries if there are symptoms of shock present or if the child is unconscious, burned, or bleeding extensively. Lesser injuries, such as a cut that requires stitches for example, can be treated where the parent has indicated on the emergency card.

   Sudden illness that occurs at the center which involves fever and skin rash or stiff neck should be routed to a hospital that has a pediatrician on the staff. Any child who has difficulty breathing or is difficult to rouse would best be directed to the nearest facility.

C. What to do in case of serious injury away from the center:

1. Always carry:

   a. A First Aid Kit
   b. Phone numbers for Poison Control and local hospitals
   c. Signed Emergency Cards for all children on the trip
   d. Any medication required by children, plus Syrup of Ipecac, in a locked box.

2. Assess the situation.

3. KEEP CALM.

4. Follow the instructions given in B 1-7 above.

5. In case of suspected poisoning, call Poison Control before administering any first aid.

6. If a child must be taken away for treatment, the adults remaining at the scene should explain the incident to the other children.

7. Adults involved in the incident should fill out an accident/injury report.

IV. Recording Injuries and Illness

A. Forms are designed to document the health status of a child and to facilitate communication between the center staff and the parent.

B. All forms used should be confidential documents between the day care center and the child's parent.

C. Standardized forms should be completed.

  1. Before the child enters the center, Child Information Emergency Cards:

     a. DSS - Form 3731
     b. Local day care information cards

  2. After an illness/injury occurs, accident of illness reports:

     a. DSS 3311: Child Care Organization Accident or Illness Report
     b. City/University Day Care Project Accident/Illness Report Model Form (Appendix E)(or similar form).

V. Choking

It is important to know how to handle a choking victim.

A. Review the film, "Choking, To Save a Life."

B. Review emergency steps; see the choking poster.

C. Practice emergency care techniques on infant manikins.

SESSION II

Treating Specific Injuries

I. Introduction

In the first session we included an overview of First Aid--how to handle emergencies on and off-site and the importance of recording injuries. Last, the choking film was presented and the techniques demonstrated. Today we would like to provide you with information about First Aid for injuries which are most likely to occur in young children. This will be a review for those of you who have taken a First Aid course. It is intended to stress those specific emergency situations that are most likely to occur at the preschool age or in the day care setting.

Minor injuries such as lumps and bumps, bites, and stings will be presented first. These will be followed by "major" injuries which include shock, burns, poisonings, etc.

Please feel free at any time during this presentation to ask questions which refer to the condition being addressed.

II. Specific Minor Emergencies

A. Lumps and Bumps

1. This is the most common injury in children in day care.
2. There may be swelling around an injured area.
3. Check for a break in the skin, a scratch, or a small cut--any wound that causes a break in the skin can become infected.
4. If there are no cuts, apply ice to the affected area. Keep the child under observation for a more serious injury, particularly if the child has a significant head injury, limps, or continues to complain of pain.
5. Record the incident and the first aid provided.
6. Inform the child's parent.

B. Scratches

1. Try to find out the source of the injury (e.g., metal).
2. Wash the scratch with soap and water for five minutes or as long as the child will tolerate.
3. Cover the scratch with a dry, sterile dressing (band-aid).
4. Record the incident and the first aid provided.
5. Inform the parent. Urge tetanus immunization if the child's immunizations are not current.

C. Splinters

1. Do not remove the splinter unless it is protruding above the skin surface.
2. Use tweezers to remove protruding splinters.
3. Clean the area with soap and water.
4. Apply a band-aid.
5. Record the incident and the first aid provided.
6. Inform the parent.

D. Bites

1. Any bite that causes a break in the skin can become infected.
2. Cleanse the area with soap and water for five minutes. You may hold the area under running water for two to three minutes if it is not bleeding profusely.
3. If bleeding, apply direct pressure for five minutes.
4. Do not apply antiseptic, ointment, or medication as these may mask possible infecting agents if a culture is required.
5. Determine if there is a need for stitches. Stitches may be needed if there is a deep ragged cut, bleeding which doesn't stop, or a severe bite on the face.

6. Apply a dry sterile bandage.

7. Notify the parent to call the child's physician for further instructions.

8. If unable to locate parent, call the child's physician for further advice.

9. Record the incident and the first aid provided.

10. If the child receives an animal bite, try to capture the animal or get information about it (a description of its location) and contact the appropriate authority.

E. Stings

1. Identify the stinging insect, if possible.

2. Remove the stinger, if present

    a. Use tweezers or scrape it off.
    b. Squeezing between the fingers and thumb may embed the stinger.

3. Cleanse the bite with soap and water.

4. Apply a cold compress or apply a solution (¼-tsp. meat tenderizer mixed with 1 tsp. water; or baking soda and water) which helps to prevent itching.

5. Record the incident and the first aid provided.

6. Inform the parent.

7. If the child is allergic to the sting use emergency medicine as prescribed.

    a. Remove stinger
    b. Apply cold compress
    c. Notify parent or physician

8. Observe the child for a reaction.

    a. Usually occurs within six hours but may take as long as 24 hours.
    b. Reactive symptoms are itching and swelling.
    c. Children known to be allergic should wear long sleeves, trousers, and shoes on a field trip.

F. Nosebleeds

1. Have the child sit with the head up.
2. Gently squeeze the soft part of nose together for at least five minutes.
3. Keep the child quiet for at least one half hour after the nosebleed.
4. If bleeding recurs, pinch nostrils for ten minutes.
5. If bleeding continues longer than fifteen minutes, consult a physician.
6. Notify the parent.
7. Record the incident and the first aid given.
8. To prevent nosebleeds:
    a. Nosebleeds occur more frequently in winter in rooms with forced air heat.
    b. Add moisture to the air by placing pans of water near radiators, vents, etc.

G. Tooth Displacement (tooth out)

1. Baby tooth
    a. Keep the tooth for the dentist to examine.
    b. Call the dentist and report the incident.
    c. Follow the dentist's advice.
    d. Notify the parent.
2. Permanent tooth
    a. Rinse the tooth off if dirty.
    b. Replace the tooth in it's correct space.
    c. If unable to replace the tooth, keep the tooth moist (tap water is sufficient), and follow steps of G 1 c and d.
3. Record the incident and first aid given.

III. Specific Major Emergencies

A. Shock: Always treat for shock with any major injury.

1. Definition:

Inadequate blood circulation to vital organs.

2. Symptoms:

- a. Pale, cool, clammy skin.
- b. Weak and rapid pulse.
- c. General body weakness.
    - 1) These may appear immediately or may be delayed for an hour or more.
    - 2) Symptoms are more likely to occur with serious injury, e.g., broken bones, head injury, and burns.

3. First Aid:

- a. Keep the child lying down. Do not raise the child's feet if she has a head injury, an unsplintered fracture, or has difficulty breathing.
- b. Cover the child only to keep her from losing body heat. (It is better for her to be slightly cool than overly warm).
- c. Continue to observe the child until medical care can be obtained.
- d. An injured person can die from shock rather than from the injury that caused the shock. Further information about shock is available from the American Red Cross.

B. Poisoning

1. Suspect poisoning:

- a. If the child exhibits any berry color on her mouth or fingers.
- b. If the child is seen holding a container of anything which seem poisonous.
- c. If the child has an unusual odor on her breath.
- d. If another child reports some unusual ingestion.

2. First Aid Procedure

- a. Be wary of antidotes listed on bottles because some have caused more damage than the substance ingested.

   - b. Call your local Poison Control for advice.
     - 1) Describe what was taken and the amount, if known.
     - 2) Give the name, age, and weight of the child.
     - 3) Follow the recommendations given.

3. A frequent remedy is Syrup of Ipecac

   - a. Keep a one-dose vial in the center's locked box.
   - b. Give the child the amount prescribed by the physician.
   - c. Follow with copious amounts of water or with coke if the child will not drink water.
   - d. The child should vomit 10 to 30 minutes after the Syrup of Ipecac is given. (Be prepared with a pan and towel.)
   - e. The child may continue to vomit for several hours after the Ipecac is given--every time she drinks liquid.

4. Notify the parent.

5. Record the incident and the name of the physician giving advice.

6. Further reference material on poisoning may be obtained from American Red Cross pamphlets.

C. Burns

1. In treating burns there are three objectives of first aid:

   - a. To relieve the pain
   - b. To prevent contamination
   - c. To give care for shock

2. There are three varieties of burns:

   - a. Thermal: caused by heat
   - b. Sunburn: caused by ultraviolet rays
   - c. Chemical burns

3. Burns are classified according to the depth or degree of skin damage incurred.

   - a. 1st degree burns: Reddened skin
   - b. 2nd degree burns: Blisters
   - c. 3rd degree burns: Deep tissue damage

4. Pain is relieved by excluding air in 1st and 2nd degree burns.

    a. Submerge the area in cold water or apply a cold pack for one hour or until the pain subsides.
    b. Cover the burn with a thick dressing; use the dressing listed in the first aid kit handout.
    c. Do not apply ointments.
    d. Do not break blisters.
    e. Record the incident and the first aid given.
    f. Inform the parent.

5. Treatment for 3rd degree burns:

    a. Apply a thick dry dressing (e.g., sheet, gauze) to burned area.
    b. Treat the victim for shock immediately.
    c. Third degree burns warrent immediate medical attention; refer to emergency management procedures.
    d. Record the incident and the first aid given.

6. Chemical burns

    a. Wash the burn completely with large quantities of water for five minutes.
    b. Cover it with a clean dressing or cloth.
    c. Notify the parent to contact the child's physician.
    d. Follow instructions given in emergency management procedures. (Model Health Forms Section, "What to Do in Case of a Serious Injury at the Center.)
    e. Record the incident and the first aid given.

7. Sunburn

    a. Mild (1st or 2nd degree burn):
    Apply cold wet packs; apply dressing if blisters appear.
    b. Severe (3rd degree burns):
    Provide immediate medical attention; treat for shock; follow procedures for 3rd degree burns.
    c. Record the incident and the first aid provided.

D. Broken Bones

1. Suspect the limb is broken if these signs are present:

    a. Swelling
    b. Tenderness to the touch
    c. Deformity
    d. Discoloration
    e. Bone protruding through the skin

2. First Aid:

   a. Keep the child lying down.
   b. Immobilize the injured part.
   c. Apply a cold compress to the swelling part if the skin is not broken.
   d. Cover the broken skin with a dry dressing.
   e. Treat the victim for shock.
   f. Follow emergency procedures.
   g. Notify the parent or local physician.
   h. Record the incident.

E. Sprains

1. Sprains are difficult to distinguish from closed fractures.

2. Symptoms:

   a. Swelling
   b. Tenderness
   c. Pain on motion
   d. Discoloration

3. First Aid:

   a. Immobilize the injured part.
   b. Apply cold, wet compresses or ice to the area.
   c. Notify the parent and seek medical attention.
   d. Record the incident and the first aid provided.

F. Severe Cuts

1. First Aid

   a. Wash out the area with soap and water.
   b. Apply direct pressure to stop bleeding.

2. Stitches may be required if:

   a. The cut is an irregular tear.
   b. Bleeding is difficult to control.
   c. The cut appears on the child's face.

3. Apply a dressing when bleeding is controlled.

4. Notify the parent or local physician.

5. Record the incident and the first aid given.

G. Significant Head Injury

1. These are most likely to have occured:

    a. With a blow to the back of the head
    b. With a fall where a cracking sound is heard
    c. When the child is unconscious
    d. When the child appears stunned

2. If the child shows no sign of injury or only a small lump or bump

    a. Continue to watch for:
        1) Vomiting
        2) Difficulty in arising from sleep
        3) Headache
        4) Bleeding from ears, nose, or mouth
        5) Progressive mental confusion or disorientation
    b. Record the incident.
    c. Inform the parent to continue to observe for symptoms for 24 hours from the time of the incident. Standard procedure is to suggest to parents to awaken the child every 2 hours during the night to make sure the child is not unconscious.

3. If the child is stunned:

    a. Keep the child lying down.
    b. Wait until the child is aroused.
    c. Watch for signs of increased injury.
    d. Wash any open wound with soap and water.
    e. Control any bleeding.
    f. Apply a dry bandage.
    g. Notify the parent and the local physician.
    h. Follow instructions from the physician.
    i. Parents may have to awaken the child every two hours during the first 24 hours to observe her for awareness.
    j. Record the incident and the first aid provided.

4. If the child is unconscious:

    a. Call emergency rescue to move the child.
    b. Notify the parent to meet you at the hospital.
    c. Record the incident and the first aid provided.

H. First Convulsion

(This applies to children with known seizures only if the child has had several seizures in a row or does not regain consciousness following a seizure.

1. Prevent injury by:
   a. Not forcing anything between the child's teeth
   b. Not hindering the child's movements
   c. Clearing away any dangerous objects near the child.

2. Adults observations are important. Describe:
   a. How the child behaves during the seizure
   b. The length of the convulsion
   c. Any illness or fever or unusual behavior noticed before the seizure

3. Positioning after the seizure:
   a. Turn the child's head to the side.
   b. Loosen clothing around her neck.
   c. Smaller children may be held over lap with face down.

4. The child may be sleepy afterwards: allow her to rest or sleep.

5. Notify the parent and follow emergency procedures.

6. Record the incident, observations, and first aid given.

RESOURCES

An Inexpensive First Aid Kit*

You may make your own inexpensive first aid kit out of an old 3-pound coffee can with a tight-fitting plastic lid. The can should be painted a bright color and clearly labeled, "First Aid Kit." See your druggist or surgical supply house for the contents.

Contents of a First Aid Kit

50	1" adhesive compresses (band-aids)
6	large size adhesive compresses
2	3" bandage compresses
1	4" bandage compresses
12	3" x 3" gauze pads
4	2' roller bandages
3	medium-size surgical dressings
1	pr. blunt tip scissors
3	triangular bandages
1	tweezers

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*Adapted from an American Red Cross handout.

Follow-up Suggestions for the Trainer

Present the workshop on Common Illness.

Consult with staff to develop specific First Aid Procedures for the center.

Have a working session to develop a Safety Check List specific to the individual center.

Present a working session to develop a Health Policy specific to the center.

Offer a working session to help the center develop a recording system for individual children's health care.

Observe in the center to see if ideas presented are being carried out (e.g., the center's purchasing Sigh of Relief, staff members attending CPR classes or standard First Aid classes).

Lend books to the center (Red Cross Primary Guide First Aid Packet).

Give a working session to develop First Aid units for preschoolers using the Red Cross Primary Guide Packet as a base.

Present a Mini-First Aid module for parents during naptime or an evening parent's meeting.

Conduct a review session for center staff on specific emergency First Aid as required.

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A Model Health Policy

Lynn Collins Clarke
Marcia Van Fossen

Introduction

The model health policy for Child Care Centers reflects the concept of health prevention, that is, promoting wellness and preventing illness or injury. A specific policy or procedure is established to follow in case of illness or injury.

The model health forms were compiled to help day care centers develop and standardize a health monitoring system.

The health policies and accompanying health forms are meant as a self-instructional packet to be adapted to the specific needs and/or services offered by individual day care centers.

Recommended Immunization Schedule

2 MONTHS	Combined Diptheria-Tetanus-Pertussis (Whooping Cough): 1st shot Trivalent Oral Polio Vaccine: 1st dose
4 MONTHS	Combined Diptheria-Tetanus-Pertussis: 2nd shot Trivalent Oral Polio Vaccine: 2nd dose
6 MONTHS	Combined Diptheria Tetanus-Pertussis: 3rd shot Trivalent Oral Polio Vaccine: 3rd dose
12 MONTHS	Tuberculin Test
15 MONTHS	Measles: may be given as combination Measles-Rubella or Measles-Mumps-Rubella
18 MONTHS	Combined Diptheria-Tetanus-Pertussis: booster shot Trivalent Oral Polio Vaccine: booster dose
4-6 YEARS	Combined Diptheria-Tetanus-Pertussis: booster shot Trivalent Oral Polio Vaccine: booster dose

Note:

For public kindergarten entrance, child must receive DPT, Oral Polio booster, and Rubella vaccine if not given previously.

It is strongly recommended that for day care situations, Hard Measles/Rubella Vaccine should be required for entrance to protect children from the possibly severe side effects of this illness.

It is recommended that Rubella/German Measles Vaccine be required for all children to protect any pregnant females working in the center from possible birth defects associated with exposure to this illness.

Health Record-Keeping

1. All children must have an initial Health Appraisal (DSS-3305) completed by a licensed health practitioner within 30 days of enrollment; this should include a record of all immunizations. The health appraisal should be repeated every two years.

2. All children must have a signed emergency card (DSS-3731) upon entrance to the center. It is strongly recommended that there be two signed emergency cards for each child: one set to be kept in the center, the other set to accompany children on every field trip. Emergency cards must be reviewed every two months for accuracy.

3. Parents of all children must complete a Health and Developmental Intake Form (See Appendix A) within 30 days of their child's enrollment. These must be reviewed by the child's teacher or primary caregiver within 45 days of the child's enrollment.

4. All children shall have a Health Supervision Checklist (See Appendix B) kept in their child's file. These should be filled out within 45 days of child's enrollment.

5. A notation of all illnesses or accidents occuring in the center shall be kept in the child's file and a copy shall be given to the parent or guardian when the child leaves the center that day. (A log is an acceptable substitute, but must be shown to the parent.) A sample Injury/Illness Form is included in Appendix E. If illness or accident results in death or hospitalization of a child, DSS form 3311 shall be forwarded to DSS within four days.

6. Parents must be notified if any child in the center has a communicable disease. Such illnesses should also be reported to the local health department.

Illness Policy

1. A child shall not attend day care if she;

   a. Has a temperature of 101 degrees or above.
   b. Has a communicable disease (See Appendix C).
   c. Has vomiting/diarrhea.
   d. Feels too unwell to participate in usual daily activities.

2. A child may return to the day care center when:

   a. Fever has been absent for 24 hours.
   b. Nausea, vomiting or diarrhea has subsided for 12 hours.
   c. Stage of contagion for specific communicable disease has passed.
   d. Four doses of penicillin (antibiotic) over 24 hours has been given for known strep infection.
   e. Child has been under a doctor's care and the doctor has given permission for child to return to the center.
   f. Child feels well enough to participate in activities at the center.

3. Sudden Illnesses:

   a. If a child becomes ill at the center, the director or teacher will exercise discretion in calling parent.
   b. All children shall be removed from the center if they display symptoms of communicable disease or severe illness.
   c. If a child seems unwell, has a slight fever below 101 degrees, director will inform parent and find a quiet place for child to rest until she goes home.
   d. If a child appears excessively ill, the center will follow instructions given by child's local physician over the phone until parent arrives.
   e. A written report of observations, etc. will be given to parent(s) upon their arrival and a copy kept for child's folder. (See Injury/Illness Report Model Form.)
   f. All items used by the ill child will be washed in hot soapy water.

Consultant for Illness: Public Health Nurse:
Ann Arbor: 994-2790
Ypsilanti: 482-9710
Out-County: 973-1460

Emergency Management Policy*

1. All local emergency phone numbers should be posted by telephones with outside lines. (See Appendix D.)
2. The center will clean minor cuts and scrapes with warm, soapy water and apply a bandage.
3. The center will apply ice to minor bruises.
4. The center will apply direct pressure to nostril for five minutes to treat minor nose bleeds.
5. The center will remove splinters that are not embedded.
6. For other accidents/injuries which may require medical attention first aid will be given and parents notified.
7. If unable to reach parents, center will contact child's physician or local emergency room. The center will follow specific instructions given by a phsyician or nurse over the phone. The center will continue to try to notify parents/relatives about the incident.
8. When transportation for medical service is required, parents have primary responsibility for providing this transportation. If the parent is unavailable or unable to transport the child, or if the center determines it is in the best interest of the child, the center will transport the child to the emergency room or physician's office and arrange to meet the parent there.
9. In any case of suspected poisoning, information will be secured from Poison Control Center immediately, before any first aid procedures are started.
10. After the emergency has been handled, a written report will be completed and filed in the child's folder. (See Appendix E.)
11. The staff will review the written emergency procedure at least twice a year. (See Appendix F.)

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*We strongly recommend that centers purchase the book, A Sigh of Relief, The First-Aid Handbook for Childhood Emergencies, produced by Martin I. Green, Bantam Books Publishers, 1977.

Medication Administration Policy

1. The center will administer only prescription medications and children's aspirin or aspirin-substitute.
2. Parent or guardian's written permission to administer medicine shall be obtained before any medication is dispensed.
3. Prescription medication shall be in the original container, stored according to instruction, labelled with specific child's name, medication's name and dosage strength along with instructions for use. The prescription must be current.*
4. Each dose of medication shall be recorded with the time and the amount given or applied. (See Appendix G.)
5. The first dose of any medication may not be given by day care personnel.
6. Medicine will be stored in a locked cabinet or locked box in the refrigerator.
7. All prescription medication shall be returned to parent or destroyed when no longer needed by the child.
8. In any case of suspected poisoning, information will be secured from Poison Control Center immediately, before any first aid procedures are started (Ann Arbor Poison Control: 764-5102).
9. After the emergency has been handled, a written report will be completed and filed in the child's folder. (See Appendix E.)
10. The staff will review written emergency procedures at least twice a year. (See Appendix F.)

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*Children's aspirin or aspirin-substitute should have the child's name and dosage written on the bottle.

Discipline Policy

1. A written discipline policy shall exist for each center and be reviewed by parent before child enters the center.

2. A written discipline policy shall be furnished to each staff person before they begin employment at the center and shall be reviewed yearly thereafter.

3. A positive method of discipline shall be used, one which encourages self confidence, self esteem, and self control.

4. No form of physical or mental abuse (shaming, humiliation, frightening child) shall be used as a discipline procedure by any staff member.

5. Withholding food may not be used as a form of discipline.

6. Non-severe discipline or restraint may be used to prevent children from harming themselves, other people, or property.

7. Inservice training for staff regarding discipline should include:

   a. Written materials regarding behavior management of children.
   b. Staff meetings used to discuss problem behavior in general and in relation to specific children.
   c. Outside consultants provided as needed for individual consultation and/or workshops.

Resources for Consultation in Ann Arbor:

Child Care Coordinating and Referral Service: 662-1127

In other communities, possible resources for consultation might be found through:

Local Community Mental Health
Local Public Health Department
Local 4 C's office
Local College/University School of Social Work

Suspected Child Abuse and Neglect

The law requires that caregivers notify Protective Services of any child they suspect suffers from parental abuse and/or neglect.

Local Suspected Child Abuse and Neglect office: 763-0134
Local Protective Services: 994-1882

Nutrition Policy
(for children 2-1/2 years and older)*

1. The center should provide at minimum, a dietary intake that follows the standards of the National Research Food Program.

   Breakfast
   3/4 cup milk
   1/2 cup fruit/juice/vegetable
   1/2 slice bread or 1/3 cup cereal

   Lunch
   3/4 cup milk
   1-1/2 ounces meat or equivalent
   1/2 cup vegetable or fruit
   1/2 slice bread or equivalent

   Afternoon Snack
   1/2 cup milk/fruit juice/fruit/vegetable
   1 slice bread or equivalent

2. Milk with a 2% butterfat content provides adequate nutrition for preschoolers and may be served.

3. Fresh fruit and vegetables should be served when possible.

4. Only 100% juice that is unsweetened should be served.

5. Whole wheat crackers, bread, and pasta should be served.

6. Desserts are allowed, but a reduction of children's intake of sugar is encouraged through the use of fresh fruit and homemade puddings, ice cream and cookies prepared with reduced amounts of sugar.

7. Children may bring treats for birthdays such as cupcakes or cake but parents are encouraged to bake their own, reducing sugar content by 1/2.

8. Children should be strongly discouraged from having pop, partial-fruit drinks, candy, potato chips, etc. in the center. Gum is forbidden.

9. Children should be encouraged to take part in food preparation as kitchen and/or food preparation regulations allow.

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*Infant formula and solid food guidelines should be followed as prescribed by the Division of Child Care Center Licensing.

10. Children should eat in a pleasant atmosphere, under adult supervision, using tables/chairs appropriate to their size and development.

11. The center shall have a written policy concerning the handling of special diets. It also shall have a written policy concerning the provision of food for field trips. (See Appendix H.)

12. All menus shall be reviewed by a qualified nutritionist yearly.

    To arrange for nutritional consultation call:

    Marion Prince, R.D.
    Washtenaw County
    U.S.D.A. Coop Extension Service
    973-9510

    Zoe Slagle, Nutritional Consultant
    State Health Department, Lansing
    (517) 373-7391

    In other communities, the local equivalent of these agencies represents the best initial resource for consultation.

Meal Preparation and Serving Policy

1. Menus shall be clearly posted and easily available to parents at least one week in advance.
2. The food preparation area shall be free of all cleaning products and insecticides, including hanging pest strips.
3. The kitchen range, hood, oven, fan, counter surfaces, etc. must be clean of all accumulated grease, spilled food and dirt.
4. Only non-porous cutting boards will be used in food preparation.
5. All dishes will be washed in a mechanical dishwasher.
6. All fresh fruits and vegetables will be washed before serving.
7. All caregivers involved in meal preparation will wash hands with soap and water before handling food.
8. All eating and serving tables will be washed with hot soapy water before and after eating.
9. All perishable foodstuffs will have adequate refrigeration.
10. All floors will be swept after each snack or meal and mopped once a day.
11. Kitchen garbage and trash containers will be covered, odor-free, and emptied daily.
12. All children will wash hands with soap and water before eating.
13. "Cooking with Preschoolers" safety rules will be followed. (See Appendix I.)

Outside Play Policy

1. The director will decide when weather is too cold for outdoor play.

2. Generally, if it is raining, snowing (more than mild flurries) or if the wind chill factor is 0 degrees F or below, young children are not sent outside.

3. While out during cold weather. children will be active--not sitting or standing still--and will be out for only 15-20 minutes at a time.

4. Children must be properly dressed before they may go outside in cold weather. Proper dress includes:

    a. A hat or hood that covers ears.
    b. Mittens that are hole-free and, if possible, waterproof.
    c. Boots which are free of leaks.
    d. Extra socks to help keep feet warm.
    e. A scarf to help protect cheeks and lips from chapping (optional).

5. Generally, a child who is healthy and well enough to attend the center, should be well enough to play outside. Some exceptions may be a:

    a. Child recovering from chest infection, e.g., bronchitis, pneumonia, respiratory flu.
    b. Child who is asthmatic.
    c. Child who has a cast or some orthopedic appliance that prevents wearing adequate outdoor apparel.

6. The center will watch for any health problems related to cold weather and will notify parents if they occur. (See Appendix J.)

7. A written report of observations and any treatment applied will be made with one copy given to parent(s) and one copy kept for child's folder.

Dental Health Policy

1. All children should have the equipment and the opportunity for toothbrushing at least once during a center day.

2. Children should receive dental health education as a unit; this will be taught by a classroom teacher or by an outside health consultant.

    In Washtenaw County, a dental hygienist student can visit your center and present a dental health prevention unit to preschoolers. To arrange for this service, call:
    Joan McGowan
    University of Michigan School of Dental Hygiene
    763-3373
    This service can only be provided winter semester, and arrangements must be made by the second week in January.

    Other communities might consider using a dental hygienist employed by the health department or in private practice, or a student from a community college-based dental assistant program or university-based school of dental hygiene.

Health Screening Services

It is strongly recommended that the day care center arrange the follow screening services:*

1. Review each child's health appraisal and health-developmental form.
   Refer questions about immunizations, past or present health problems, and/or developmental history to a public health nurse consultant or other health consultant.
2. Arrange a hearing screen on all children.
3. Arrange a vision screen on all children three years old or older.
4. Arrange a dental screen on all children three years old or older.
5. Arrange a developmental screen on at least all children of concern--as determined by staff observations or by information obtained from the health appraisal or health-developmental intake forms.

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*Hearing, vision and dental screening may be done with prior parent knowledge so that the parent has the opportunity to refuse screening, although these screenings do not require individual signed permission prior to screening. Prior written parental permission is advised for developmental screening.

Health Screening Resources

Health Consultants

Public Health Nurse Consultant:

City of Ann Arbor	994-2790
City of Ypsilanti	482-9710
Out-County (Washtenaw Health Department)	973-1460

Other communities might approach:

The local health department
A local physician who would donate time--call the local Medical Society for assistance

Hearing and Vision Screening

Washtenaw County provides hearing and vision screening to all day care centers. To confirm screening dates, contact:

Program Director
Hearing and Vision Screening Program
Washtenaw County Health Department
971-1300

Other communities should seek screening services from:

Local health departments
Local Early Periodic Screening Diagnosis & Treatment (EPSDT) clinics
Local volunteer groups, e.g., Lion's Club
Local community colleges
Private medical screening services that accept Blue Cross/Blue Shield, Medicaid, etc. payment

Dental Screening

In Washtenaw County screening by dental students under supervision is available. To arrange this service call in early fall for on-site dental screening. A nominal fee may be charged.

Community Dentistry Office
School of Dentistry, University of Michigan
763-2105

In other communities, call the local health department to see if they provide dental screening services to preschoolers, or call the local Dental Society for possible volunteer dental screening service.

Health Screening

Children requiring an entrance health appraisal who are eligible for Medicaid services may receive screening at the local EPSDT clinic. The services that are available through that clinic are listed in Appendix K.

Developmental Screening

In Washtenaw County, for developmental screening, contact:

Child Care Coordinating and Referral Service
662-1127

Or a public health nurse consultant who has the training and equipment to do the Denver Developmental Screening Test.

Or if initial screening suggests further evaluation is needed, contact:

Department of Pupil Personnel
Ann Arbor Public Schools
994-2325

Special Education Services
Ypsilanti Public Schools
482-7288

Medicaid Screening
Health Department
971-1300

Learning Evaluation Clinic
763-0450

Project Find
Washtenaw County Intermediate School District
994-8100

Early Childhood Development Program
ISMMRD
764-4115

Other communities would look to comparable agencies for developmental screening assistance.

Personnel Health and Record-keeping Policy

1. All employees and volunteers must have a health assessment signed by a physician or her designate.
2. All employee health assessments must be dated within six months prior to the first day of work or within thirty days after work begins. These should be updated every two years thereafter.
3. A verified TB test, administered by a licensed health person within three years of the beginning work date, must be presented to the center administrator before work begins. TB immunizations should be updated every three years.*
4. One full-time staff member must have Cardio Pulmonary Resuscitation (CPR) certification.
5. Salaried teachers and administrative personnel must hold a current Red Cross Standard First Aid card. These should be updated every three years.
6. In-service training for staff health education must be provided two times a year by the Public Health Nurse assigned to the center or by another health provider if necessary.
7. Staff members who are ill should not attend work if:
    a. They have a contagious disease;
    b. They feel too ill to actively participate in the day care program;
    c. They are physically incapable of providing safe care to young children due to injury or illness;
    d. They are emotionally incapable of providing adequate care to children due to some unusual or sudden circumstance.
8. A file for each employee/volunteer should be maintained which should include:
    a. Employee health examination records (initial and subsequent exams, DSS form 1528);
    b. TB testing record;
    c. Accident/incident reports.

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*Until the new DSS Child Care Center regulations are passed, TB tine testing is required every year.

Center Health Management Policy

1. The director is responsible for the center's overall health program. She may designate another staff person or volunteer as the center's health chairperson.

2. Teachers/caregivers are responsible for reporting any observed health problems, physical or emotional, to the director.

3. Any health observations involving specific children will be discussed individually and immediately with the parent(s).

4. When indicated, resources will be provided to parents to help secure needed health services.

5. Parents will be informed immediately of any contagious illnesses occurring in the center.

6. Employees who do not follow the center's written health policies will first be warned, then dismissed if change in behavior does not occur.

7. Parents who do not comply with written center health policies will be so informed. If parents continue non-compliance, the center has the right to deny further enrollment.

Health Education Policy

1. All employees who work directly with children should have knowledge about:
    a. Basic first-aid, Cardio-Pulmonary Resuscitation (CPR), and emergency care for choking.
    b. Children's health problems; especially childhood illnesses, signs of impaired vision, impaired hearing, signs of orthopedic problems, and signs of abuse and neglect.
    c. Fire, tornado, child safety procedures.
    d. Safe and adequate cleaning of center environment.
    e. Methods of teaching good health habits to children.
2. All children in the center should be taught or have the opportunity to:
    a. Practice appropriate daily health habits, e.g., handwashing, toothbrushing.
    b. Use anatomical names for body parts.
    c. Use basic safety rules, e.g., how to cross a street safely, water safety, etc.
    d. Understand the importance of nutrition and how food affects growth.
    e. Use socio-dramatic play as a means to work through emotional reactions to health care and illness, e.g., providing a stethoscope, play hospital, surgical gown, etc.
    f. Understand how "health practitioners" help children.
3. All parents of children enrolled in the center should:
    a. Review the health policy package the center has put together, especially health requirements, illness and medication policy, discipline, nutrition, and outdoor play, before the child is enrolled.
    b. Be encouraged to follow through on health practices used in the center to provide a consistent health pattern.
    c. Follow-through on screening results (e.g., hearing impairment, dental cavities, etc.) or teacher-observations related to health, and seek an appropriate health practitioner for service.

d. Be encouraged to offer ideas for ways to best maintain health in the center and ways to encourage children learning about good health practices.

Health Education Consultants in Washtenaw County:

Nancy Thompson, P.H.N.
994-2790

Child Care Coordinating Referral Service
662-1127

In other communities, the best source of health education would be the local health department Health Educator or a Public Health Nurse.

Environmental Standards Policy

1. Safety checks, including minimal environmental standards for accident prevention, will be made periodically. A suggestion is to use them with each season change. (See Appendix L.)

2. Fire safety rules will be conspicuously posted and will include instructions for site evacuation.

3. Regular fire drills, announced and unannounced, will be held at least once a month.

4. Smoking by day care personnel will be allowed only in designated areas that are off limits to children.

5. A tornado alert system including "take cover" procedures will be devised and visibly posted.

6. A "take cover" tornado safety drill will be held each month during April, May and June.

7. Sleeping facilities will include:

    a. Age-appropirate bedding (i.e., crib, cot);
    b. Rest equipment that is labelled with the user's name (crib, cot, bedding);
    c. Coverings appropriate to the season;
    d. Blankets and linens that are laundered once a week or whenever soiled;
    e. Rest equipment that is scrubbed with soap and water once a month, whenever soiled, or when used by a child with a communicable disease. (See Appendix C for explanation of communicable disease.)
    f. Crib slats that are 2-3/8" apart or less; bumper pads that extend around entire crib and tie in at least six places;
    g. A sleeping environment that is quiet, conducive to rest, and continually under supervision.
    h. Children's special rest needs (i.e., blankets, special stuffed animals, pacifiers, etc.).

8. Toilet Facilities:

   a. All toilet facilities (bowl, sink, counter, floor) must be cleaned daily.

   b. All toilet facilities must allow for independent use by a child (e.g., equipped with potty chairs, potty seats, steps, etc. as needed).

   c. All toilets must be checked daily for adequate soap, paper towels and toilet tissue.

   d. All toilet enclosures used by children must not lock.

   e. Children with special needs must be accompanied by an adult.

   f. All children will wash hands with soap and water after using the toilet facilities.

9. Diapering Facilities:

   a. Disposable diapers and disposable wipes will be used exclusively.

   b. A closed, plastic-lined trash receptacle must be provided to receive all soiled diapers and wipes.

   c. A changing table or its equivalent must be available.

   d. Changing surfaces must be cleaned with soap and water after use or protected by a disposable pad or paper sheeting.

   e. Caregivers will wash hands before and after diapering.

APPENDICES

MODEL HEALTH FORMS FOR CHILD CARE CENTERS

Lynn Collins Clarke
Marcia Van Fossen

City/University EPSDT-Day Care Project

Appendix A:

Health and Developmental History Prototype

Today's date: ____________ Enrollment date: __________

Child's name: __________________ Birthdate: _________ Age: _____ Sex: _____

Nickname: __________________

Address: ______________________________ City: _______________ Zip: ______

Father's name: _______________________ Mother's name: ______________________

Age: _____ Occupation: _______________ Age: _____ Occupation: ______________

Place of Employment: __________________ Place of Employment: __________________

Telephone: _______ Working hours: _____ Telephone: _______ Working hours: _______

With whom does child reside? _____Mother _____ Father _____ Other

If other, please explain: ____

How will your child be transported to and from school? __________________________

Other children in the family: Name(s) _________________ Age(s) ______________

Others who live with your family: Name(s) ______________ Age(s) ______________

Relationship(s) to child: ____

Pets in the family: _______________________ Names: ________________________

Dentist's name: _________________________ Address: __________________________

Telephone: ____________________________

Are parents in good health? ____

Was there anything unusual about the pregnancy with this child? _______________

Did the baby come on time? ____

Did this child require any special medical care or prolonged hospitalization at birth?

What was the birth weight? _______________

At approximately what age did your child ....

- Sit alone _____
- Crawl _____
- Walk alone _____
- Say first words _____
  - (what were they?) ____________________
- Say first sentence _____
  - (two words or more) ____________________
- Drink from a cup _____
- Feed self with a spoon _____
- Become toilet trained _____
  - Bladder _____
  - Bowel _____
  - Night time _____
- Dress self _____
  - Button buttons _____
  - Snap snaps _____
  - Zip zippers _____
  - Tie shoelaces _____

Have either you or your doctor noted that your child has had:

- _____ high fevers
- _____ earaches
- _____ toothaches
- _____ nose bleeds
- _____ frequent colds
- _____ eczema
- _____ hives
- _____ wheezing
- _____ vomiting
- _____ diarrhea
- _____ constipation
- _____ seizures
- _____ speech problems
- _____ difficulty seeing
- _____ difficulty hearing

If yes to above question, please explain how often it occurs, cause and treatment given.

____

____

Please specifically list all allergies including food, medication, insect bites or stings.

____

____

Has your child had any of the following childhood illnesses?

- _____ Chicken pox
- _____ 'Red' or 'Hard' measles
- _____ 'German' or '3-day' measles
- _____ Mumps
- _____ Meningitis
- _____ Strep throat
- _____ Impetigo
- _____ Pin worms

Does your child have any other medical or physical problems? ____________________
If yes, please explain and give name of medical person treating condition:

____

____

Any medication given regularly? ____________________

Has your child ever been hospitalized or had surgery or been treated in the emergency room? _______

If yes, please explain: ____________________

____

When did your child last:

1. Have a regular medical check-up? ______________________
   Where? ______________________________

2. Have a dental check-up? ______________________________
   Where? ______________________________________

Does your child usually eat . . .

_____ Dairy products (milk, cheese)
_____ Meat
_____ Eggs
_____ Poultry
_____ Fish
_____ Soy bean products
_____ Grain products (bread, cereal)
_____ Fruit
_____ Vegetables
_____ Peanut butter

What are your child's food preferences/dislikes? __________________________
____
____

Does your child nap? _____ How long? _____

Best way to waken: ____
____

Does your child take anything to bed at naptime? __________________________
____

What words or gestures does your child use to indicate need to use the bathroom?
____
____

Names of your children's special friends: _________________________________
____

What are your child's favorite toys, interests, TV programs or play activities?
____
____

What method of discipline do you use with your child? (e.g., send to room, sit in chair, no TV, spank, etc.)

____

____

Any previous experiences away from parents, including day care or preschool?

____

If yes, where? ______________________________

Does your child have a difficult time when you leave him/her? Explain. __________

____

If so, how do you deal with it? ____________________

____

If parents are not together, does child see absent parent? __________

How often? ______________________________

Have there been any major changes at home that would affect your child? (e.g., death, separation, divorce, distant move)

____

Is your child afraid of anything? (e.g., animals, thunder storms, the dark, etc.)

If yes, please explain: ____________________

____

____

Many children, when under stress, exhibit certain behaviors. Does your child. . .

_____ bite nails
_____ suck thumb or fingers
_____ wet the bed
_____ have nightmares
_____ have temper tantrums
_____ hold his/her breath
_____ twirl hair
_____ sleep walk

Are there skills, interests or hobbies you would be willing to bring to the center to share with staff or children? ____________________

____

Would you be interested in attending parent meetings? What time is best for you?

____

____

Is there any special information which would help us take care of your daughter/son? (e.g., any specific activities to be encouraged or restricted, special goals for your child?)

What do you expect your child to get out of our program?

City/University EPSDT Day Care Project

Appendix B:

Health Supervision Checklist

Name: ____________________

Birthdate: ____________________

Chronic Problems: e.g., allergy, asthma, seizures, nutrition/feeding, sleep, elimination

Conditions requiring emergency care: e.g., bee sting allergy

Continuous Medications:

(write year) 19							19						
Data Base (months)	Sp/Oc	Ny/De	Jn/Fe	Ma/Ap	My/Jn	Ju/Au	Sp/Oc	Ny/De	Jn/Fe	Ma/Ap	My/Jn	Ju/Au	Results/Follow-Up/Comments
Bi-monthly update of Emergency Card													
Bi-Yearly update of Health Appraisal (physical exam)													
Yearly update of Health Development Intake Form													
Screening Test--Every Year: (write numbers) Height													
Weight													
(check if done): Hearing Screen													
Developmental Appraisal													
Dental ⟩ screenings begin at 3 years													
Vision ⟩ screenings begin at 3 years													
Immunizations--write month/year (see Immunization Schedule)	1st dose (2 mo)	2nd dose (4 mo)	3rd dose (6 mo)	1 yr	15 mo	booster (18mo)	2 yr	2 1/2	3 yr	3 1/2	Booster (4 yr	5 yr)	
DPT													
Oral Polio													
TB	▨	▨	▨										
Measles/Mumps/Rubella (Should not be given until child is 15 mos. If given before that, repeat dosage)	▨	▨	▨	▨									
Other:													
Chicken Pox yes ☐ no ☐													

*Code: Use red notations fc special conditions or where follow-up is necessary

COMMUNICABLE ILLNESSES IN PRESCHOOL CHILDREN

Communicable Diseases

Disease/Problem	Early Symptoms (Prodomal)	Cause Incubation Period Occurrence	Communicable Period How Spreads	Description of Rash/Problem	Control Measures Treatment/ Prevention	Other: Including When to Report
Chicken Pox	May be no symptoms in young child. Others may not feel well generally: decreased appetite, runny nose. Fever, decreased appetite, generally not feeling well may occur with rash.	Virus. 10-21 days--usually 14 days. Winter and early spring.	1-2 days before onset to 5-6 days after pox begin, or until skin lesions are all scabbed over. Highly contagious. Spreads from skin lesions, respiratory droplets, airborne transmission.	Usually begins on head and progresses to rest of body, especially trunk of body. Can affect mucus membranes (mouth, throat). Described as "dew drop on a rose petal" progresses to small elevations containing pus.	Exclude from school for one week after eruptions occur. Lesion should be scabbed over. Articles soiled by discharge should be washed in hot water/disinfectant.	Report to health department by mail.
German Measles (3 day measles)	Non-specific in children. Adolescents may have fever, not feel well, headache 1-5 days before rash. Swollen lymph nodes behind ears.	Virus. 14-21 days, usually 16-18 days. Winter, spring	7 days before to 5 days after rash disappears. Highly contagious Spread by droplet or direct contact--especially from nose, throat secretions.	Faint, fine pink non-raised rash spreading from face to trunk. Rash spreads rapidly. Disappears by third day.	Exclude from school for one week after eruptions occur. Wash articles soiled by discharge in hot water and disinfectant. Preventable by measles/mumps/rubella vaccine given 15 months of age.	Report to health department by mail. Keep ill child away from pregnant women.

Measles (Rubeola, hard measles, red measles)	High fever, red eyes, runny nose, hacking cough 3-5 days before rash. Koplich spots (bluish-white scattered spots inside mouth) one day before rash.	Virus. 10-12 days. Late winter, early spring.	From beginning of prodomal period to four days after appearance of rash. Transmitted by nose, throat secretions of infected people, direct contact.	Red-brown small eruptions on face, behind ears. Progresses to chest, abdomen and inside extensor surface of extremeties. Covers body by third day; fades by fifth to sixth day, followed by peeling.	Exclude from school for one week after rash appears. Wash all contaminated articles in hot water and disinfectant. Preventable: Rubeola vaccine (MMR) given at 15 months of age or older.	Report to health department by mail.
Mumps	Fever, not feeling well.	Virus. 12-21 days, commonly 18 days. Winter-spring.	From six days before glands swell (2 to 9 days after swelling appears--less if swelling has subsided).	Chipmunk appearance. Swelling, tenderness of parotid gland--located near ear.	Exclude from school until swelling and fever disappears. Wash all contaminated articles in hot water and disinfectant. Preventable: Mump's vaccine (MMR) given at 15 months or later.	Report to health department by mail.
Roseola Infantum	High fever (104 degrees and above) for 3-5 days.	Virus. 7-17 days usually 10. Spring.	None definitely established.	Faint, red raised rash on trunk (later on rest of body) appears after temperature returns to about normal or normal.	Exclude from school until fever, rash disappear.	Convulsions may occur with fever. Usually occurs in children six months to four years. Most common aro one year of age.

Scarlet Fever	Fever, sore throat, vomiting, Strawberry tongue.	Streptococcus Infection Group C. 2-5 days. Late winter-spring.	Greatest when fever, sore throat are occurring. Transmitted by intimate direct contact, or large droplet infection.	Rash appears 12-48 hours after symptoms present--usually on first day of symptoms. Red, sandpapery-feeling rash. Rash blanches on pressure. Appears mostly in areas of warmth and pressure--neck, axilla, lower abdominel, groin folds, inner thigh, and spreads to entire body. Face may be flushed but skin area around mouth is pale. Rash may last up to six weeks--peeling may occur especially on finger tips.	Exclude from school until anitbiotic treatment begun (at least four doses of medicine) and symptoms have improved. Wash all articles soiled with nasal discharge in hot water and disinfectant.	Report to health department by mail. Must complete full course of antibiotic therapy: 10 days. Lock up medicine, some children may be allergic to it.
Strep Infections	Fever, sore throat, vomiting.	Streptococcus-Beta hemolytic Streptococcus. 2-5 days. Late winter-spring.	Greatest when fever, sore throat are occurring. Transmitted by direct contact, large droplet infection.	Red swollen tonsils with white patches may be present.	Exclude from school until antibiotic treatment begun (at least four doses of medicine) and symptoms have improved.	Report to health department by mail. Lock up medicine as some children are allergic to it. Medicine may need refrigeration. Loose stools may be caused by medication, especially Ampicillin.

Disease/Problem	Early Symptoms (Prodomal)	Cause Incubation Period Occurence	Communicable Period How Spreads	Description of Rash/Problem	Control Measures Treatment/ Prevention	Other: Including When to Report
Impetigo	Scratch marks, red elevations appearing on moist surfaces or creases.	Staphylococci and Streptococci. 2-5 days.	While lesions are weeping. Spread by direct contact.	Red blisters filled with straw colored fluid which open and crust on face, ears, neck and sculp.	Exclude from school until weeping lesions crusted over. Strep infections need antibiotics, Staph infections need ointment--both of which must be prescribed by an M.D. Wash all soiled articles with hot water and disinfectant. Keep hands clean.	May occur with sore throat. Report by mail to health department.
Viral and Bacterial Conjunctivitis (Pink Eye)	Increased tearing and irritated eyes.	Viral or Bacteria. Estimated 5-6 days, usually 24-72 hours. Often occurs with respiratory illnesses during cold seasons.	During first few days of illness. Direct contact with discharge or upper respiratory tract of infected person.	Red streaks in eyes. Weeping from eyes. Eyelids may swell. Eyelids may be crusted shut in morning and after nap.	Exclude from school until weeping subsided. Wash soiled articles with hot water and disinfectant. Treatment with ointment or drops which must be prescribed by an M.D. Teach children to keep fingers out eyes. Keeps hands washed.	Report to health department by mail. Children under five most suseptible. Incident decreas with age.

Disease/Problem	Early Symptoms (Prodomal)	Cause Incubation Period Occurence	Communicable Period How Spreads	Description of Rash/Problem	Control Measures Treatment/ Prevention	Other: Including When to Report
Pinworm	Itching near anal area.	Enterobiasis Vermicularis, Intestinal round worm in man. 2-6 weeks usually two weeks.	Throughout infection. Transfer of eggs from perianal skin to mouth by contaminated hands, food, air or substances which carry eggs (sandboxes).	Itching near rectum. Later stages--irritability, disturbed sleep.	No isolation required. Wash all articles and toilet seat with hot water and disinfectant until 24 hours after medicine given. Usually treat entire family. Medication must be prescribed by an M.D. Educate importance of improved hygiene--especially hand washing.	Eggs only survive a few days after leaving infected person. Not reportable to health department except in outbreaks.
Ringworm	Small solid elevation on skin which spreads.	Fungus. 10-14 days.	As long as lesions present. Direct or indirect contact, especially toilet articles or clothing contaminated with hair from man or infected animals (dogs, cats, cattle).	Round red elevations spread peripherally leaving grey scaly and itching patches. Usually bald in patch areas.	Exclude from school until treatment given and child cured. Wash all soiled articles with hot water and disinfectant. Check animals in center for possible source of infection. Educate about personal hygiene.	Check back of head, neck and behind ears for symptoms. Report to health department so that PHN may come and screen other children.

Disease/Problem	Early Symptoms (Prodomal)	Cause Incubation Period Occurrence	Communicable Period How Spreads	Description of Rash/Problem	Control Measures Treatment/ Prevention	Other: Including When to Report
Lice--Head	Scratching of scalp.	Louse. Variable--average 8-9 days. However, eggs may live as long as 35 days.	Until all lice and eggs are destroyed. Direct contact with infected hair or infested clothing, bedding.	Identify nits. Appear as whitish dots attached to hair shafts. Itching and infected scratch marks.	Exclude from school until treated. Must see doctor. Treatment--Kwell usually one shampoo. Wash all soiled articles in hot water and disinfectant. Dry using hot cycle. Educate about personal hygiene. Isolate cot--spray with R & C Spray.	Check back of head, neck and behind ears for symptoms. Report to health department so that PHN may come and screen other children.

Disease/Problem	Early Symptoms (Prodomal)	Cause Incubation Period Occurence	Communicable Period How Spreads	Description of Rash/Problem	Control Measures Treatment/ Prevention	Other: Including When to Report
Scabies	Small, non-elevated pale pink spots on skin with wavy, threadlike, slightly greyish burrows.	Mite which lives on people. Several days to 4-6 weeks.	Duration of illness. Direct contact with person or infected article.	Elevations/ lesions itching which may become secondarily infected. Itching intense at night. Infection several days to weeks before itching occurs. Usually appear in finger webs, palms, soles, head, neck in children because of constant facial contact.	Exlusion from school until doctor seen and condition treated adequately. Wash all soiled articles in hot water and disinfectant. Dry using hot cycle. Isolate cot and spray with R & C Spray from pharmacy. Must see doctor; treatment: Kwell lotion. Educate to improve personal hygiene.	Report to ment so PHN can screen other children. Single infections in family uncommon. Itching following treatment is common.

Common Respiratory Illnesses

Illness	Symptoms	Communicability	Treatment	Control	Complications
"Colds"	Some combination of nasal congestion or scratchy throat less than 101 degrees.	First few days after onset of symptoms.	Symptomatic: Cold steam, fluids. Aspirin or Tylenol for fever. Rest. 1/2-teaspoon honey and lemon juice for cough. Call M.D. if fever persists more than two days or other symptoms persist more than 1 week.	Essentially none.	Otitis Media and Croup are common in this age group.
Viral "flu"	Often begins with malaise, sore throat, headache, sneezing, sniffling, fever followed by cough which persists.	Usually considered communicable so long as fever persists.	Symtomatic as for cold. Call M.D. for advice if: 1. Fever is greater than 101 degrees. 2. Fever lasts longer than two days. 3. There is a persistant cough. 4. Any symptoms of respiratory distress appear, i.e., flaring nostrils, retractions, increased number of respirations.	Essentially none.	Otitis Media Bronchitis Pneumonia

Illness	Symptoms	Communicability	Treatment	Control	Complications
Acute Otitis Media	Usually follows a "cold" or "flu" but may have sudden onset, may or may not have fever, often there is fussiness and "gooey" eyes. Four and five year-olds may complain of earache or pressure sensation in ear. Parent or teacher may note hearing loss. If the tympanic membrane ruptures, may see yellow discharge on pillow.	------	Absolutely must see M.D. 1. Antibiotic for ten days prescribed by M.D. 2. Aspirin or Tylenol for pain or fever. 3. Depending on M.D. some decongestant/antihistamine such as Actifed, Dimetapp may be prescribed. 4. Treatment includes an "ear-check" to insure antibiotic therapy was effective.	No prevention. Tends to occur on the same child repeatedly, with similar symptoms.	May be followed by Serous Otitis Media (common) or complicated by Meningitis, Abcess or Mastoiditis (uncommon).
Viral Croup	Mild: barking cough, stridor. More severe: suprasternal and intercostal retractions, fearfulness and anxiety. Occurs more often at night.	Often associated with a cold.	1. Cold steam. 2. Fluids 3. If child does not improve or distress increases, call physician or go to emergency room. 4. Severe croup may require hospitalization.	No specific prevention.	Severe respiratory distress.

Illness	Symptoms	Communicability	Treatment	Control	Complications
Epiglottitis (rare)	Child appears very ill, has difficulty swallowing, drools, is very restless, may be pale or blue in addition to having barking cough and stridor.	Usually caused by H. Influenza bacteria.	Medical Emergency: Requires immediate transport to Emergency Room.	---	Severe respiratory distress.
Allergic Rhinitis	Stuffy nose, cold symptoms without fever that persist beyond a week.		Requires the advice of a physician. Some medication is required to control symptoms. Some commonly used drugs are: Benadryl, Actifed and Dimetapp.	Avoid things child is allergic to when known.	Serous Otitis Media
Serous Otitis Media "Glue Ear"	Hearing loss, pressure sensation in ears.	Can occur with colds.	Requires the advice of a physician. Medicines such as Actifed and Dimetapp may be used for six months. If no improvement often Tympanostomy Tubes are inserted, especially if significant hearing loss occurs.	----	Most common cause of conductive hearing loss in preschool children.

Illness	Symptoms	Communicability	Treatment	Control	Complications
Asthma	Wheezing, coughing, difficulty in breathing.	In young children, often provoked by some respiratory infection.	Child may be on routine drug care or may have a drug at the center to be used if attack begins. Common drugs used: Quibron, Elixophyllin.	Avoid things child is allergic to when known.	Pneumonia Status Asthmaticus

Common Medical Problems

Illness	Symptoms	Communicability	Treatment	Control	Complications
Fever with no other symptoms.	100 degrees or less is normal. 100 degrees to 101 degrees is mild and need not be treated for most children. 101-103 degrees is a moderate fever. 103-105 degrees is a high fever.	Unknown	Moderate fever: Aspirin, Acetaminophen. Remove outer clothing. High fever: Alternate aspirin with Acetaminophen every two hours or give aspirin and Acetaminophen together for one dose until parent arrives. All drugs should be given with signed parental permission.		Depends on cause of fever.

Illness	Symptoms	Communicability	Treatment	Control	Complications
Diaper Rash	Red, raw looking rash in diaper area.	Can be spread by hand contact if caused by Monilia.	No plastic or rubber pants; no Pampers. Air dry. Desitin ointment, A & D ointment, zinc oxide. Recommend parent change detergents if using cloth diapers Mycolog can be prescribed for Monilia infections which must be diagnosed and treated by an M.D.	-----	Secondary bacterial infection.
Vomiting with no other symptoms	Usually lasts 3-6 hours if viral gastroenteritis.	May be viral GI "flu" and hence contagious.	Give nothing for 3-4 hours, then small amounts frequently of jello water, Kool-aid, Gatorade, flat Coke, ginger ale.	Remove child from other children. Good handwash technique for caregivers.	Dehydration: Symptoms: No urine or decreased amount. No tears when crying. Fever, sunken eyeballs.
Diarrhea	Symptoms last 1-2 days in viral gastroenteritis. In a 1-2 year-old, 2-3 loose stools a day may persist for several days.	May be viral GI "flu" and hence contagious.	Give water first, then add Kool-Aid, Gatorade, Coke, ginger ale.	Remove child from other children. Good handwash technique for caregivers.	As above.

Illness	Symptoms	Communicability	Treatment	Control	Complications
Urinary Tract Infection	Fever, burning, frequency, "fishy" smelling urine. Urinary tract infection should be suspected whenever a girl has an undiagnosed fever.	None	Child must see an M.D., must have urinalysis done, must have some drug therapy to treat infection. Often in children the drug is Gantrisin, but there are many others.	Encourage frequent bladder emptying and increased fluid intake.	Kidney involvement, scarring of ureter valves.

Appendix D:

Medical Resources for Young Children Currently Available in Ann Arbor/Ypsilanti

EMERGENCY CARE:

Trauma Care (broken bones, accidents, cuts that need stitches):

St. Joseph Emergency Room
572-3000

University Hospital Emergency Room: Poison Control
764-5102

Pediatric Medical Emergency Care:

Pediatric Walk-In Clinic
763-1271
Pediatrician Available
Hours: 8:00 a.m. - 12:00 midnight
University Hospital (after 12:00 midnight)

Emergency on-site care: telephone 911

CLINICS:

Well Child Care;

1. Child Health Clinic
   University Hospital: North Outpatient Building, Ann Arbor
   764-5160 for appointment
   Hours: Mon. Tues. Wed.: 1:15 to 3:00 p.m.
   Thursday: 9:00 to 12 noon
   Need University Registration ($3.00)
   Clinic Cost ($3.00). Take Medicaid Card.
   Pediatrician and Nurses Available

2. Nurse Well Child Clinic: (1 - 5)
   555 Towner Street, Ypsilanti
   482-9710 for appointment
   Monday: 9-11 a.m.
   Thursday: 1:15-3 p.m.

3. Nurse Well Baby Clinic (0 - 12 mos.)
   555 Towner Street, Ypsilanti
   482-9710 for appointment
   Tuesday: 9-11 a.m.
   1:15-3 p.m.
   Saturday (1st & 3rd): 9-11 a.m.

4. Immunization Clinic
   School-aged well children (5 - 18)
   Adult TB tests
   555 Towner Street, Ypsilanti
   "Walk-In Clinic" no appointment needed
   Saturday (2nd & 4th): 9-11 a.m.

5. Nursery School Age Well Child Clinic (5 - 18)
   555 Towner Street, Ypsilanti
   482-9710 for appointment
   Saturday (3rd): 9-11 a.m.

Full Service Clinics (Well and Ill)

1. Bryant Community Clinic
   2201 Hemlock Ct., South East Ann Arbor
   971-9494 for appointment

Dr. Marshall Little	Hours:	Monday:	1-5 p.m.
		Tuesday:	2-10 p.m.
		Wednesday:	2-6 p.m.
		Thursday:	1-5 p.m.
		Friday:	1-5 p.m.
		Saturday:	9-1 p.m.
Sue Brumgraber, PNP	Hours:	Saturday:	9-1 p.m.
OB/Gyn Practitioner	Hours:	Monday:	1-5 p.m.
		Tuesday	2-10 p.m.
		Wednesday:	
		Thurs.-Fri.:	1-5 p.m.

Maternal/Child Health M.D. Hours: Wednesday: 7-10 p.m.

2. Summit Medical Clinic
   704 Spring Street (off Miller Ave.), Northwest Ann Arbor
   769-4445

   Dr. Edward Pierce and Dr. Dave Lyman, General Practitioners

   Hours: Monday thru Friday:
   9-12:30 p.m.
   1:30 to 5:30 p.m.

   Saturday: by appointment

3. Packard Community Clinic
3174 Packard Road
971-1073

Dr. Jerry Walden, Family Practitioner

Hours:	Mon. Tues. Thur.:	10:00 to 12:00
		1:30 to 5:00
	Wed. Eve.:	7:00 to 9:00
	Friday:	10:30 to 12:00
		1:30 to 5:00

Dr. Maggie Dolan, Family Practitioner

Hours:	Mon. Tues. Wed.:	9:00 to 12:30
		1:30 to 5:30
	Thursday:	1:30 to 5:30
		7:00 to 9:00
	Friday:	10:30 to 12:30

Doctors are on duty some Saturdays, call Clinic.

Speciality Clinic

Genetic/Heredity Clinic, for Sickle Cell test (electro-phoresis)
University Hospital
763-2532 for appointment; Mrs. Sundling

Meets every other Wednesday 2 p.m.

Pediatricians Currently Accepting New Patients Who Will Accept Medicaid Patients:

Group Practice:

Child Health Associates
2522 Packard Road (Georgetown Mall)
Ann Arbor
971-9355
Sick calls: 971-9344
Physician in the group accepting new patients:

- Dr. Mary Roloff
- Dr. John Dayton
- Dr. Howard Weinblatt

Two Nurse Practitioners on staff

Solo Practice:

Dr. Robert Brougher
606 W. Stadium Blvd.
Ann Arbor
665-6155

Dr. Allen Dumont
911 Brown
Ann Arbor
769-3702
Two Nurse Practitioners on staff

Dr. John Gall
940 Maiden Lane
Ann Arbor
994-5858
A Nurse Practitioner on staff

Appendix E:

Injury/Illness Report Model Form*

DATE:

TIME OF INJURY/ILLNESS NOTED:

NAME OF CHILD:

TYPE OF INJURY/ILLNESS (include time of day):

HOW OCCURRED/SYMPTOMS:

TREATMENT GIVEN:

REPORTED BY WHOM:

---

* We recommend using NCR or other carbon-like paper when filling out this report. One copy should be kept by the day care center and the other given to the parent(s).

Appendix F:

What to Do in Case of a Serious Injury at the Center

1. Follow First Aid instructions for the specific type of injury.
2. Get help from another adult who can assist (director, teacher).
3. While first aid is in process, get emergency card from office.
4. Notify parent, or failing that, the child's physician or the nearest emergency room.
5. Arrange transportation: this can be a staff car, parent's car or 911 vehicle as need determines.
6. Accompany child as needed (two adults to one child). Do not send one parent and a seriously injured child alone to the Emergency Room. You may determine the best action is to meet the parent at the Emergency Room.
7. Choose the nearest hospital for all serious injuries, (e.g., there are symptoms of shock present, child is unconscious, burned, bleeding extensively). Lesser injuries, such as a cut that requires stitches, can be treated at the facility the parent has indicated on the emergency card.

Sudden illness that occurs at the center which involves fever and skin rash or stiff neck should be routed to a hospital that has a pediatrician on the staff and provisions for isolation. However, any child who has difficulty breathing or is difficult to rouse would be best directed to the nearest facility.

Appendix G:

Authorization to Administer Medication

I, ______________________________, the parent or guardian of ________________ ______________________________, authorize the day care center to administer the following prescribed medication for a period of ____________________ (number of days) beginning ________________________ (date).

I understand that the staff will follow the directions printed on the prescription label. In order for the staff to accept medication for a child, it must be brought to school in the original bottle or container with the prescription label attached. The label must state the name of the physician, the name of the medicine, the dosage, the child's name and the date.
It must be a current prescription.
I will sign a separate authorization for each medication that my child is to receive. I understand that because of the possibility of an unknown allergy, no first dose of any medication will be given by day care personnel.

Name of medication: ____

Dosage and directions for administering: ______________________________

____

Prescribed by: ______________________________ Phone: ________________

____
(signature of parent or guardian)

RECORD OF MEDICATION ADMINISTERED IN CENTER

Date	Time	Amount	By whom (signature)

Appendix H:

Dietary Exceptions Policy

Before enrollment, parents of children on special diets must review the center's menu and present any necessary modification, in writing, to the center. The center has the right to decide if they can can or cannot meet the needs of a child on a special diet.

Once a modified menu has been agreed upon by center and parents, the menu should be reviewed by the child's physician and/or nutritionist. Any time center menus are changed, this process should be repeated. If food regulations allow, an alternative to a modified center menu. is a sack lunch from home.

For children with known food allergies, the child's name and food(s) must be clearly posted next to the food serving area in the center.

Food for field trips, whether it be brought from home or provided by the center, must have adequate refrigeration provided by the center.

Appendix I:

Cooking with Preschoolers--Safety Considerations

1. Discuss safety rules with children before the activity begins and during the activity (e.g., when water is getting hot, point at which heat should be turned off, etc.).
2. Keep size of group small.
3. Check equipment to make sure it is in good working condition.
4. Be present when electrical appliances are in use.
5. Make sure that all ingredients and utensils are accessible.
6. Use large bowls to help prevent spills.
7. Help children become aware of sharp utensils and their correct use.
8. Know where the fire extinguisher is and how it is used. (If there is a small fire and extinguisher is not readily available, cover fire with lid of pot or dump baking soda on fire to eliminate the supply of oxygen. NEVER PUT WATER ON ELECTRICAL OR GREASE FIRE as that will spread flames).
9. The participation of parents in cooking experiences provides extra supervision (as well as several other pleasurable aspects).
10. Be aware of any regulations about the presence of children in nursery school or public kitchens.

Appendix J:

Health Problems Related to Cold Weather

Health problems that can occur from cold which might be seen in preschoolers are:

1. Chapping

   Many children have sensitive skin and some are more prone to chapping than others. A good preventive measure in children known to get chapped cheeks or lips is to apply a thin film of vaseline. For children who are observed to have chapped skin after being outside, treatment is the same. Chapping is rough, reddened, cracked or fissured skin.

2. Frostbite

   This is not likely to occur in a properly dressed child in a supervised outside play experience; however, early or first degree frostbite is possible. First degree frostbite is red, tender, may appear slightly edematous (swollen) and is most likely to occur on hands, feet, ears, cheeks and nose. If frostbite is suspected two important do nots are:

   a. Do not rub frostbitten part with snow.

   b. Do not expose frostbitten part to intense heat such as hot water or a radiator.

   Do cover exposed area with another warm body part, for example, cover a frostbitten cheek with a warm hand or immerse in tepid (never hot) water.

Appendix K:

EPSDT--Protocol for Children Under Six

Every child must be accompanied by a parent, guardian or adult relative.

The screening requires the following components:

Completion of a Health History Form including immunization history, by a parent or guardian.

Hearing Screen--all ages

Vision Screen--over age three

Denver Developmental Screening Test

Height and Weight

Blood Pressure--age five and up

Hematocrit (test for anemia)

Sickledex Test for Sickle Cell Trait

ZPP technique screen for lead level in blood

Urine test for sugar and albumin

Unclothed physical inspection by a nurse

Conference between the nurse and parent for interpretation of screening tests and referral if needed

Parents will receive a written health summary sheet (see the form which follows).

City/University EPSDT-Day Care Project

REPORT OF HEALTH SCREENING SUMMARY

Date Screened ____________

NAME	BIRTH DATE	SEX	PARENT OR GUARDIAN
ADDRESS			PHONE - Home Work
PHYSICIAN'S NAME & ADDRESS			PHONE
DENTIST'S NAME & ADDRESS			PHONE

I. HEALTH HISTORY . . . . As reported by parents . . . .

A. IMMUNIZATIONS

IMMUNIZATIONS	Dates			Booster
Diphtheria				
Tetanus				
Pertussis				
Polio (Oral)				
Measles (Rubeola)				
Rubella				
Mumps				
Other				

B. TUBERCULIN TEST

Type: Date: Result:

C. Conditions which may require emergency care such as allergies, fainting, diabetes, seizures or other: ____________

D. Health problems which need special attention or care: ____________

II. SCREENING TESTS

SCREENING TESTS	Within Normal Limits* Yes	No	Where Referred, Already Under Care, or Other
Hearing			
Vision			
Height (inches):			
Weight (pounds):			
Blood Pressure:			
Hematocrit (%):			
Sickle Cell			
Blood Lead			
Urine Sugar: Alb:			
Denver Developmental Screening Test			

(If delays, describe sector and recommendations) ____________

III. PHYSICAL INSPECTION

PHYSICAL INSPECTION			
General Appearance			
Cranium, Hair & Face			
Ears, Eyes & Nose			
Mouth & Teeth			
Skin			
Chest & Back			
Abdomen			
Muscle Tone			
Arms & Legs			

IV. ADDITIONAL RELEVANT HEALTH INFORMATION

____

Date ____________

Signature ____________

Agency & Address ____________

*MDPH-MCH/EPSDT Standards for Health Screening/1974

Form No. H-658a 12/76

Appendix L:

Safety Check ☑ List

- Indoor Environment -

Yes	No	
☐	☐	Are emergency telephone numbers (nearest hospital, police, fire, rescue, poison control) and center address posted by each telephone?
☐	☐	Is a telephone with an outside line immediately accessible to staff in an emergency?
☐	☐	Are infant, toddler, preschool and special needs' children always directly supervised both indoors and out, and are responsible adults notified of the whereabouts of school-age children?
☐	☐	Are all medicines kept in locked containers, in their orignial containers, labeled with the original prescription label and inaccessible to children?
☐	☐	Are these items inaccessible to children: all toxic materials, cleaners, scouring powders, liquid or powder detergents, pesticides (bug sprays, strips, pellets, bait boxes)?
☐	☐	Do all non-toxic materials (paints, art materials) have a separate storage area?
☐	☐	Are there any poisonous indoor plants accesssible to children?
☐	☐	Are all aerosal cans inaccessible to children and stored away from heat sources?
☐	☐	Are all loose plastic bags and styrofoam objects (other than those lining trash cans or filled with material) inaccessible to children who are still putting objects into their mouths?
☐	☐	Are all objects less than 1" in diameter or objects with removable parts less than 1" in diameter inaccessible to children who are still placing objects in their mouths?
☐	☐	Are there safeguards to prevent children from entering unsupervised or hazardous areas, e.g. locks, bolts?
☐	☐	Are all room surfaces (including ceilings) free of peeling paint or plaster, cracks and holes?

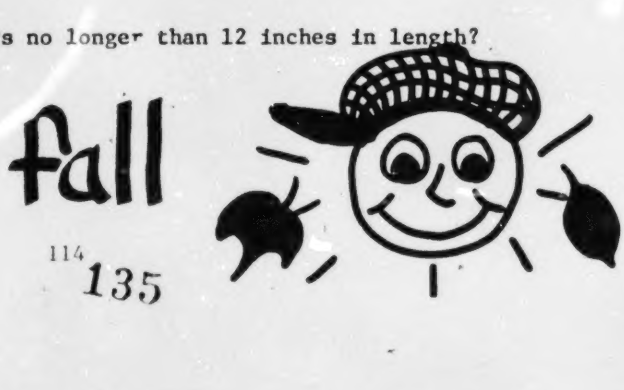
Yes	No	
◡	◠	Do all passageways used bypass hazardous areas such as boiler rooms and kitchen cooking equipment?
◡	◠	While in use, are all heat sources exceeding 110° F (heaters, hot water pipes) which are located in child-use areas shielded from children?
◡	◠	While operating, do all floor, desk, and pedestal fans have covers or guards which have openings smaller than 1-1/2 inch?
◡	◠	Are all non-used electrical outlets filled with special protective receptacle covers in all areas occupied by children under five years?
◡	◠	Is all electrical equipment made inaccessible to children by furniture placement or other precautions?
◡	◠	Are all electrical equipment or cords more than one foot away from a water source?
◡	◠	Is the facility free of loose or frayed electrical wires?
◡	◠	Is all electrical equipment used with children certified by Underwriters Laboratories?
◡	◠	Do doors swing so that visual observation of stairs is possible?
◡	◠	Are there landings or gates provided beyond each exterior and interior door which opens into a stairway?
◡	◠	Do all inside stairs used by children have right-hand descending handrails which are in good repair?
◡	◠	Are all stairways well lit by artificial or natural light?
◡	◠	Are all stairs and stairwells used by anyone in the site free of stored items?
◡	◠	Do all stairwells, elevated walkways, elevated porches and elevated play areas that are accessible to children have barriers to prevent falls?
◡	◠	Are all windows above ground floor level which are accessible to children, constructed, adjusted or adapted with window stops, inoperable locks, or grills to limit the exit openings?
◡	◠	Are floors free of raised or rough edges to prevent stumbles?
◡	◠	Can all locked doors to closed spaces (e.g. closets, bathrooms) always be opened by an adult?
◡	◠	Are center exits and exit routes clearly marked by signs?

Yes	No	
☐	☐	Are all exits and exit routes unobstructed?
☐	☐	Do all exit doors swing in the direction of exit travel?
☐	☐	Do all exits have only one locking device which can be unlocked from the inside?
☐	☐	Is the site's evacuation procedure conspicuously posted?
☐	☐	for fire?
☐	☐	for tornado?
☐	☐	Is the site's fire alarm conspicuous, operating and audible?
☐	☐	Are fire extinguishers placed in accordance with fire regulations for your center?
☐	☐	Are there written safety rules for indoor and outdoor activities, and are they known to staff and children?
☐	☐	Are all first-aid containers fully equipped?
☐	☐	Are child care areas otherwise safe, well-lit and well maintained?

Safety Check List

-Toy Safety-

Yes	No	
☐	☐	Are all dangerous objects inaccessible to children, e.g. sharp scissors, tools, nails, glass containers?
☐	☐	Are all toys and equipment free of peeling paint, sharp edges, loose parts, rough areas, exposed bolts--especially center-made toys?
☐	☐	Are riding toys stable, well-balanced and in good condition, e.g. gears covered by casing?
☐	☐	Are all toys age appropriate, e.g. not too heavy?
☐	☐	Have all projectile toys been removed from play area?
☐	☐	Are all metal toys made of non-lead material and free of holes or sharp edges which could cut or scratch?
☐	☐	Are all stuffed animals in good repair and clean?
☐	☐	Are all dolls in good repair and clean?
☐	☐	Are all broken toys or equipment inaccessible to children?
☐	☐	Is all play equipment free of pinch or crush points, e.g. fast-closing toy box lids or doors, hinged legs)?
☐	☐	Are all toys with small parts, which could be lodged in any body orifice, out of reach of children under three years?
☐	☐	Are all plastic toys made of flexible plastic? (Brittle plastic toys should be discarded.)
☐	☐	Are strings attached to toys no longer than 12 inches in length?



Safety Check ☑ List

-Outdoor Play Area-

Yes	No	
☐	☐	Is the play yard enclosed with a fence that is in good condition (no sharp protrusions) and a gate that closes securely?
☐	☐	Is the play area free of broken glass, bottles, metal tabs and other debris?
☐	☐	Is play equipment which needs it securely anchored, e.g. swings, climbers, etc.
☐	☐	Is play equipment at least six feet away from fences, walk and other obstructions?
☐	☐	Are all exposed screws or bolts on play equipment capped?
☐	☐	Is play equipment free of rings or holes which could trap a child's head? (An opening between 5" and 9" is hazardous.)
☐	☐	Is play equipment free of exposed hooks and links in which a child's finger could be caught? (Especially "S" type hooks, and large link chains?
☐	☐	Is play equipment free of sharp edges, splinters or rusty areas?
☐	☐	Are play areas free of places where stagnant water can or does accumulate?
☐	☐	Is the surface underneath play equipment resilient to cushion falls, i.e. grass, earth, sand, tanback?
☐	☐	Has broken equipment been removed from the play area?
☐	☐	Are there poisonous plants or shrubs within confined play yard?
☐	☐	Are children protected from street traffic where they ride their bikes or trikes?

Yes	No	
◡	◠	Are outdoor areas free of any business, commercial or social functionings when children are present in the same area?
◡	◠	Are children protected from street traffic at drop-off and pick-up points for the center"
◡	◠	Is there a minimum ratio of two staff members, one of whom is a caregiver, for every seven children outside?
◡	◠	Are outdoor play areas otherwise safe?

-Play Equipment-

SLIDES: (Must be securely anchored)

◡	◠	Are slides equipped with non-slippery steps and rims or rails to protect side edges and ladders?
◡	◠	Are metal slides shaded from the sun?
◡	◠	Are wooden slides waxed or oiled?

SWINGS: (Must be securely anchored)

◡	◠	Are swing seats lightweight, flexible and non-cutting?
◡	◠	Are there chair swings for children under three years?
◡	◠	Are worn spots and holes under the swings filled with protective material?

SANDBOX:

◡	◠	Is the sandbox shaded from the sun?
◡	◠	Is the sand raked often to keep it clean and expose it to sun and air?
◡	◠	Is the box covered at night to protect it from moisture, dogs and cats?

CLIMBING STRUCTURES: (Must be securely anchored)

◡	◠	Are bars secured so they do not turn when grasped?
◡	◠	Have playground rules been reviewed by staff and children, e.g. equipment should not be used when slippery or wet?

Safety Check List

-field for trips-

Yes No

☐ ☐ Have all parents signed a blanket field trip permission form and been informed of this trip?

☐ ☐ Is there a minimum ratio of two staff members, one of whom is a caregiver, for every seven children?
(It is strongly recommended that the staff/child ratio be increased to two staff people for every five children if visiting a crowded public area).

☐ ☐ Are emergency telephone numbers (nearest hospital, police/fire/rescue, poison control) with staff members accompanying children?

☐ ☐ Are up-to-date signed emergency cards available to each vehicle driver and/or staff member to carry on a field trip?

☐ ☐ Have transportation/traffic safety rules been reviewed with the children before this trip?

☐ ☐ If snacks or lunches are included in the field trip, are proper food/health precautions provided, including adequate refrigeration?

☐ ☐ Are all emergency medications inaccessible to children (locked in trunk or glove compartment or carried in an adult's purse), labeled with the original prescription label and in the original container?

☐ ☐ Is each vehicle equipped with a fire extinguisher in proper working condition?

☐ ☐ Is each vehicle equipped with a first aid kit as outlined in DSS rules for child care centers?

☐ ☐ Do vehicle seat belts/child restraint systems meet DSS rules for child care centers?

☐ ☐ Are all vehicles in proper working order (horn, tires, brakes) and do they meet the Michigan vehicle safety code?

☐ ☐ Does each volunteer driver comply with standards set down in the DSS rules for child care centers?